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Analysis of Management Behavior Assessments

and Affect on Productivity

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U.S. Army-Baylor University Graduate Program in

Health Care Administration

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Disclosure

In accordance with Army Regulation 360-5, Army Public Affairs, the views and opinions expressed in this study are not reflective of official policy of the Department of the Army, Department of Defense, the U.S. Government or Baylor University.

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Undertaking this body of research proved more difficult to tackle than originally anticipated. Conceptualizing predictors of management behavior is relatively straightforward, but the actualization of reaching quantitative measures to validate the affects of management behavioral attributes presented the need for extensive query, as well as development of a reliable assessment instrument. The research design process repeatedly presented more questions than conclusions to relationship theories, emerging as lofty goals slight of real value added as a scientific body of work. Surmounting the trials and tribulations associated with this graduate project was accomplished with the assistance and support from professors, colleagues, and family.

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Abstract

The basis of this study originates from the identification of management behavioral attributes within executive skill competencies necessary in the successful management of military treatment facilities (Virtual Military Health Institute, 2003). The need exists for constructing a reliable behavior assessment instrument that captures data operationalized into correlational relationships between hospital management and employee beliefs of management behavioral attributes. The objectives of this research study are to determine if significant correlations exist between employee perceptions of management behavior in comparison to management's perception of own behavior, to explore the predictability of hospital productivity based on the assessment of such behaviors, and to design a reliable behavioral assessment instrument. The research design combines cross-sectional, formal, exploratory, and correlative ex post facto design elements. Data on respondent demographics and beliefs of management behavioral attributes was collected by administering two survey instruments; one to a population of military officers serving in management positions (N=49), and the second to a stratified random sampling of hospital employees (n=502). Statistical analysis confirms that significant relationships exist between hospital management self-assessment and employee attitudes and beliefs of management behavioral attributes. The method of study posits the basis for a more precisely controlled longitudinal study across multiple medical activities purporting the prediction of causal relationships between management and employee assessments of behavioral attributes.

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Introduction

The Department of Defense (DoD) is the single largest employer of federal civilian service workers throughout the United States, employing in excess of 642,000 civilians (United States Office of Personnel Management, 2004), and over 1,425,000 military personnel (DoD, 2004). Within the United States Army, over 222,000 civil service personnel (United States Office of Personnel Management, 2004) and 489,000 military service members (DoD, 2004) are employed full time; making the Army the largest employer within DoD. Similarly, Darnall Army Community Hospital (DACH) is the largest employer of civilians on Fort Hood, Texas; employing over 850 federal civil service employees, over 700 contract civilians, and is home to over 710 military service members (MEPRS, 2004). As an organizational entity, DACH has a work environment of disparate proportions in terms of the number of civilian workers compared to the number of military, greater than a two to one ratio. Such disparity raises the issues surrounding workforce diversity, organizational culture, the relationship management shares with employees, and the impact of management behavior on organizational productiveness.

Conditions Prompting the Study

Within DOD's military health system (MHS), Darnall Army Community Hospital (DACH) is considered a medical activity defined with the capability of handling Level Three trauma patients based on both the medical specialists assigned and operational status of advanced medical equipment. Moreover, the hospital's primary mission is to provide healthcare to the military community surrounding Fort Hood consisting of active duty soldiers and their family members within a forty-mile catchment area. Since the beginning of the Global War on Terrorism (GWOT) Fort Hood has deployed both of its maneuver divisions (4th Infantry Division and 1st

Cavalry Division), the III Corps Headquarters, and most of the 13th Corps Support Command. Within the maneuver divisions and the 13th Corps Support Command, military service personnel from DACH filled vacant medical positions under the Professional Officer Filler System (PROFIS). In the absence of these medical service members, many having critical medical subspecialties and skills, DACH was backfilled with activated Reservists and National Guard soldiers. Although the number of active duty service members decreased with the deploying divisions, the active duty family members remained, and Fort Hood transformed into a pre-deployment site for thousands of mobilized National Guard and Reserves headed to either Iraq and/or Afghanistan in support of GWOT. As it would seem that DACH's medical mission would decrease in terms of volume of patients needing healthcare compared to the number of available providers, the demand in treating the unfit and ill prepared Reservists and Guardsmen actually increased patient volume. The departure in conditions of patient volume coupled with the turnover from active to reserve military personnel prompted this study of DACH, the research environment as a military hospital setting in the course of GWOT, management behavioral attributes, and envelopes the impact on the beliefs of hospital employees.

At the close of fiscal year 2004, extending into 2005, DACH continues to undergo change as activated Reservists and National Guard service personnel reach the end of their mandatory service obligation and are released from active duty, and the twice deployed PROFIS providers and soldiers return from combat duty to again fill positions at the hospital. In conjunction with the turnover in military personnel, the DACH federal civil service workforce is undergoing its own transformation with an average six percent turnover with more employees leaving than filling vacancies (MEPS, 2005). Organizational culture promotes the conditions that motivate

employees and determine employee level of commitment to remain employed, take early retirement, or quit. The assertion that a correlation exists between organizational management and employee beliefs of management behavioral attributes with comparative relevance to productivity forms the basis of study using DACH as an example to capture the divergence of behavioral beliefs amid military officers serving in management positions with those of the remaining hospital workforce.

The influence of management behavior affects employee beliefs and attitudes, and impacts organizational productivity. Employees depend on managers for guidance. More specific, employees are dependent on managers to clarify task instructions, interpretation of organization policies and objectives, and timely dissemination of critical information. When the lines of communication between managers and employees are interrupted or lingering as management disregards employee concerns, the manager falls into unfavorable view with employees. Managers that give the impression of not caring breed the perception amongst employees that the organization does not care; and is directly relative of ambivalent management behavior (McConnell, 2003). Effective managers are expected to lead people and the organization, instill the goals of the organization's strategic plan, and serve as the foundation for the organization's culture. Herein, ultimately the culture of the work environment transfixes organizational success.

The necessity for continuous changes in business processes has far reaching influence on the culture of medical facilities as a means to keep pace with the transformations in medical technology, increasing elderly patient population, and aging workforce. Changes to existing ways of doing business bring about employee dissatisfaction. Managers are challenged by

employee views and beliefs resultant of implementing new processes coupled with increasing diversity in the workforce. Diversity in today's and tomorrow's medical organizations arises from escalating minority populations and international medical graduates hired to replace retiring Baby Boomers and to fill shortages in the medical profession. Management's own behavior in dealing with such cultural changes will either facilitate change or degrade organization effectiveness. Management behavior is important because strong managers focus on attributes of leadership, commitment, customer-patient satisfaction, employee involvement and empowerment, interdepartmental cooperation, continuous improvement, and recognize quality as major themes of strategic management (Huq & Martin, 2000). As strong managers work to instill these major themes, employees view changes to the work environment either positively or negatively. Failure of managers to deal with employee and/or departmental divergence, if dealt with at all, will have a lasting problematic impact on the organization. The same holds true for employee assessment of management practice, skill set, and behavior.

Problem Statement

There is a need for research in the determination of hospital performance based on facility cultural environment and the impact, measurable through correlated variances, if any, across divisions within the hospital, as well as between similar military treatment facilities. Like any organization, hospitals must assess present measures of effectiveness to maintain viability in a volatile health care market. Although federal medical treatment facilities (MTFs) are removed from the competitive nature of like civilian institutions, managers of federal facilities too must exercise business change processes to meet existing demands, such as maintaining facility readiness in accordance with JCAHO standards while supporting the demands of the Global War

on Terrorism. As Department of Defense (DoD) MTFs continually change to keep pace with an evolving military force and patient population, leader assessment strategies of effectiveness have become necessary.

Background

In 1996, the Joint Medical Services in conjunction with the Office of the Assistant Secretary of Defense for Health Affairs instituted a measure to ensure competent management of MTFs. In order to ensure that only fully qualified officers commanded DoD medical facilities, coupled with the provisions specified by the 2001 Defense Authorization Act, the Joint Medical Executive Skills Program (JMESP) was born (Virtual Military Health Institute, 2004). Deemed necessary of today's successful health care executives, the JMESP addresses demonstrable behaviors of 40 core competency skill sets drawn from eight primary competency zones (Virtual Military Health Institute, 2003). The zones of coverage targeted for this research study included general management, health law and policy, health resources allocation and management, ethics in the health care environment, individual and organizational behavior, clinical understanding, and performance measurement. The eighth competency zone not included in this study is military medical readiness. Military medical readiness primarily revolves around the preparation of soldiers to deploy into hostile lands, and because this area is military exclusive, it was discarded to avoid response bias. From within the targeted zones, the body of research surrounds the behavioral attributes of 25 out of the 40 required skill sets of competent medical professionals. Out of the 40 core competencies, the following JMESP skill sets were identified for use in the research study: 1) strategic planning, 2) organizational design, 3) decision making,

4) managing change and innovation, 5) leadership, 6) public law, 7) medical liability, 8) medical staff by-laws, 9) regulations, 10) human resource management, 11) labor-management relations, 12) facilities management, 13) ethical decision making, 14) personal and professional ethics, 15) bioethics, 16) organizational ethics, 17) individual behavior, 18) group dynamics, 19) conflict management, 20) communication, 21) clinical investigation, 22) quality management, 23) quantitative analysis, 24) outcome measurements, and 25) clinical performance improvement (Virtual Military Health Institute, 2003).

The study of management behavior is important because although there are numerous studies on employee or worker behaviors and productivity, management behavior is least considered as a root cause of variant changes in hospital performance measures. Previous studies associated with the affects of management behavior on employee beliefs and attitudes; include Herzberg's Two Factor Theory, Vroom's Expectancy and Equity Theories of Motivation, the Ohio State and University of Michigan Leadership Studies, Blanchard's Leadership Model, and Anderson's Behavioral Model. The premise of Herzberg's Two Factor Theory (Herzberg, Mausner, & Snyderman, 1959) looks to answer what motivates employees and the satisfaction employees experience within an organization. The Herzberg Theory (1959) hypothesizes that workers are satisfied with their jobs when personal goals are achieved, when recognized, when given additional responsibility, and when advanced in job position. Vroom's Expectancy and Equity Theories of Motivation (Vroom, 1964) look to explain the conscious choices workers make. For example, workers believing to work hard will perform at higher levels with the expectation of receiving comparable performance rewards. The Ohio State and University of Michigan Leadership Studies (Stogdill & Coons, 1951; Kahn & Katz, 1960) look

to identify effective leadership behaviors. Each study concluded that leadership behavior is centered either on organization production or employee relations, but herein, does not address the affect of management behavioral attributes on employee productivity. Leadership as a dimension of management behavior, is addressed by Blanchard's Leadership Model (Hershey & Blanchard, 1974) as consisting of four competency based leadership styles (i.e., directing, coaching, supporting, and delegating), each having a different impact on organizational productivity. Furthermore, Anderson's Behavioral Model (Anderson, 1968) postulates that the organizational environment is comprised of predisposing, enabling, and need characteristics. All of the above theories provide a basis for management behavior research, but neglect to present significant factors specifically between hospital management behavior and employee beliefs and attitudes of management.

A behavioral study conducted by Cassell, Johnson, and Smith (1997), posited that a significant correlation exists between the influence of organization ethical codes and employee behaviors and attitudes. Ethics drive the organizational vision and values, directly influencing the attainment of the organization's mission, and in no other working environment is this dimension of management behavior more imperative than in hospitals. Within the hospital work environment, ill wanton ethical behaviors have negative consequences on the outcomes of patient care. The ethical behavior displayed by management directly influences the ethics and values of employees. In comparison to their corporate counterparts, medical professionals are held to an even higher standard of ethics sworn to protect the health and welfare of patients, physicians are sworn under the Hippocratic Oath not to cause harm, all providers must report adverse events, and health care administrators battle with ethical decisions when limiting patient

care based on catastrophic caps and other resource constraints. When patients are turned away from receiving treatment or sustained treatment is ceased due to patients' inability to pay, ethical decisions are being made between charitable health care and maintaining the financial viability of the hospital as a competitive organizational entity. From the employee perspective, maintaining organizational viability is least considered when management must make such financial decisions, and often unbeknownst, these decisions directly impact the hospital's capability to continue employing the hospital staff. Herein, the communication between management and employees must address ethical codes of conduct to avoid misinterpretation of business practices, as well as to foster an environment that does not tolerate unethical practices. Employees need to be able to report refractory events without fear of reprisal, knowing that something will be done to rectify such events from occurring in the future. Porter, Steers, Mowday, and Boulian (1974) conducted a study demonstrating that organizational cultures promoting open lines of communication between management and employees, as well as encouraging feedback, have the highest levels of commitment to organizational values and ethical codes of conduct.

In order for today's health care facilities to remain viable entities in a continuously changing environment, physicians, non-physician providers, and administrative executives and managers have to adopt new methodologies for conducting business. The influences on leadership of a health care environment in turmoil reached one of many pinnacles during the 1990s, prompting health service researchers to undertake extensive analysis in preparation to cordon an advancing health care juggernaut. One of the earliest studies of the 1990s, undertaken by Hudak, Brooke, Finstuen, & Riley (1992), involved two separate Delphi projects drawing upon the expertise of

senior medical military officers serving as Deputy Commanders for Administration (DCA) and Hospital Commanders. The purpose of the study was to seek a consensus among senior health care executives on what skills and competencies were necessary to ensure the success of future health care administrators. The results of both studies identified nine health care skills, knowledge areas, and abilities: 1) cost and finance, 2) leadership characteristics, 3) professional staff interactions, 4) health care delivery concepts, 5) accessibility to care, 6) ethics, 7) quality and risk management, 8) technology, and 9) marketing (Hudak, Brooke, Finstuen, & Riley, 1992). In comparison to the JMESP core competency skill sets, not too much has changed over the last one and a half decades. The four domains of cost and finance, health care delivery, access, and quality were reported as the majority of responses (69.5%) most likely to confront future military treatment facility leaders. Whereas, the remaining competency dimensions of technology (10%), professional staff (8%), leadership (4%), marketing (4%), and ethics (4%) accounted for the remaining response frequencies. The relationship of significant correlations between the group ratings of DCAs and Hospital Commander ranged from .72 to .96 for all domains except for the quality and risk management dimension having a correlation rating of .52. In comparison, Coile (1997) conducted a study to capture the critical success factors for Chief Executive Officers (CEOs) of civilian hospitals and health systems (relative equivalent to military DCAs and Hospital Commanders), and identified vision (85.5%), strategic thinking (83.5%), personal integrity (74.2%), the ability to change (55.6%), and risk taking (49.4%) as the necessary top five traits. In addition, Coile (1997) identified communication, leadership, team building, physician relations, and management skills as necessary characteristics for future health care leaders.

In contrast to the numerous studies on employee or worker behaviors, management behavior is least considered as a root cause of changes in organization productivity; and often when considered, there is little statistical reference to support broad based assertions. According to Hejna and Hosking (2004), in order to achieve operational efficiency, hospital management needs to develop and conduct modern clinical and business processes, lead by efforts to acquire the latest technologies in clinical equipment and information systems, based on adopting proactive, yet disciplined, behavioral attributes. Operational efficiency is achieved by harnessing five critical strategies: 1) generating an organizational vision that is clearly understood by everyone, 2) embracing change ideas and innovative thought, 3) conducting interdepartmental and multidisciplinary structured planning processes, 4) fostering participation and ownership, and 5) reinforcing hospital goals and strategic objectives (Hejna & Hosking, 2004). Research literature has shown that recognized/successful organizations have increased productivity through identifying the need for change in management behaviors. Reflective of management behavior is management competencies. Competencies are defined as skills, knowledge, and attitudes that are directly correlated with job performance (Shewchuk, O'Connor, & Fine, 2005). The relationship between behavior and competency serves conjunctively with the affects of management behavioral attributes on organizational performance, effectiveness, efficiency, and/or productivity. Herein, the relativity of management behavioral studies undergoes scrutiny and affirmation for possible utilization by an Army medical activity (MEDDAC) sharing similar environmental conditions and analogous organizational processes.

The American Medical Association (2003) enlisted a study to identify leadership challenges of executives and found that the 60% of respondents identified an organizational environment

challenged by getting people to work together; followed by balancing competing demands and priorities (56%), motivation and inspiration of employees (45%), balancing organizational needs against employee needs (42%), adjusting to faster paced and multidimensional responsibilities (37%), staying connected to employees (34%), building optimism (32%), and establishing credibility and building trust (27%). In a management self-assessment and employee assessment of management decision-making attributes, Field and House (1990) utilized the Vroom and Yetton decision-making model of group leadership in order to prove that decision quality is a significant determinant of overall decision-making effectiveness. The research study sample size consisted of 44 managers and 44 subordinate employees with average ages of 41.5 and 39.7 years of age respectively. In comparison of education, 61 percent of managers had at least a bachelor's degree or higher, while 45 percent of the subordinate employees had a bachelor's degree or higher. The results of the study proved the validity of the Vroom and Yetton theory, but the employee assessments of management decision-making did not support the model (Field & House, 1990). Managers need to demonstrate multidimensional characteristics based on behavioral attributes necessary in support of executive competency skills sets. One such mechanism in recognition of necessary behavioral attributes rests with management leadership responsibilities. According to McConnell (2003), managers must accept responsibility for the actions (or inaction) of employees, place the well being of employees and the organization above his or her own, support the organization's strategic plan, ensure the training and development of employees, facilitate group thinking, and characterize the role model of leadership.

McConnell's tenets of leadership speak to the inner core of the Joint Medical Executive Skills Competencies and rationale for this research study. A secondary intent of this study is to design

a behavioral assessment tool for hospital management by which self-assessments and employee assessments of management behavior serve as an instrument for performance measurement. The intent behind the assessment tool is to identify weaknesses in management behavioral attributes in order that he or she will adjust, modify, and improve upon self in support of organizational goals. Second, the assessment tool is intended to identify the significance of relationships between the JMESP management behavioral attributes. Third, the assessment tool is intended to identify the significance of relationships between the JMESP management behavioral attributes and employee perceptions of that behavior. Lastly, the management behavioral assessment tool presents a mechanism by which behavioral data is attributable to productivity measures of the medical treatment facility (MTF).

Purpose

The purpose of this study is to present a meaningful analysis of management behavioral attributes in relation to how the same attributes are perceived by the rest of hospital staff. This study attempts to draw upon the existence of significant relationships that may, or may not exist between the perceptions of both management and employees towards management behavior. The expanded scope of this study, given the culture and setting of the DACH work environment, targets the identification and assessment of personnel character differences in order to predict modalities of performance. Moreover, this study explores the utility of behavior assessments as a useful predictor of organizational productivity.

Research Objectives

The objectives of this research study are to determine if significant relationships exist between DACH employee perceptions of management behavior in comparison to management's

perception of own behavior. Second, to explore the predictability of hospital productivity based on the assessment of such behaviors (causal explanation between variables). Third, design a behavioral assessment tool and instrument for DACH management to assess own performance and to make inferences of why organization productivity levels increase and/or decrease. In addition, such a tool presents an internal perspective of managerial skills as well as demonstrable behavioral attributes in comparison to organizational performance. Dependent upon the outcome of demographic data collected, this research contributes to the outlook of determining if the work environment (i.e., atmosphere, operational tempo, culture, and personnel turn-over) affects MTF performance; if cultural diversity (i.e., rank, age, gender, civilian education, training, and/or military experience) affects MTF performance; if attitude and/or personal beliefs affect MTF performance; if leadership traits affect MTF performance; and if management practices affect MTF performance. The methodology of analysis for management behavior assessment is represented on the proceeding page in Figure 1.

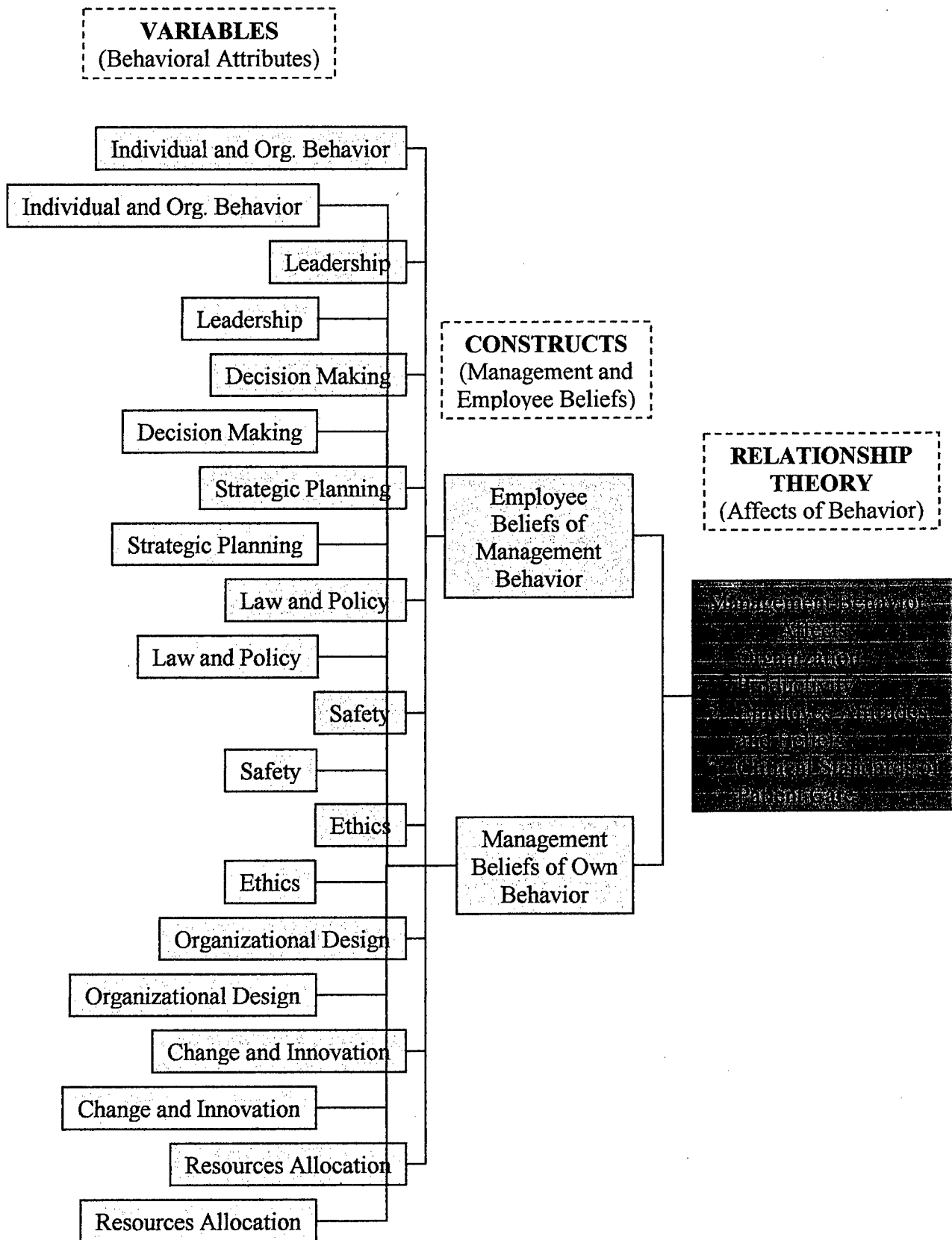


Figure 1. Management behavior methodology of analysis.

Hypotheses/Research Questions:

1. Management behavior affects organization productivity.
2. Management behavior affects employee attitudes and beliefs.
3. Management behavior affects clinical standards of patient care.

Alternate and Null Hypotheses

Working Hypothesis:

Null Hypothesis (H_0): There is no difference between management behavioral self-assessment and employee assessment of management behavior.

$$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5 = \mu_6 = \mu_7 = \mu_8 = \mu_9 = \mu_{10} = \mu_{11} = \mu_{12} = \mu_{13} = \mu_{14} = \mu_{15} = \mu_{16} = \mu_{17} = \mu_{18} = \mu_{19} = \mu_{20} = \mu_{21} = \mu_{22} = \mu_{23} = \mu_{24} = \mu_{25} = 0$$

Where μ_1 =strategic planning, μ_2 =organizational design, μ_3 =decision making, μ_4 =managing change and innovation, μ_5 =leadership, μ_6 =public law, μ_7 =medical liability, μ_8 =medical staff by-laws, μ_9 =regulations, μ_{10} =human resource management, μ_{11} =labor-management relations, μ_{12} =facilities management, μ_{13} =ethical decision making, μ_{14} =personal and professional ethics, μ_{15} =bioethics, μ_{16} =organizational ethics, μ_{17} =individual behavior, μ_{18} =group dynamics, μ_{19} =conflict management, μ_{20} =communication, μ_{21} =clinical investigation, μ_{22} =quality management, μ_{23} =quantitative analysis, μ_{24} =outcome measurements, and μ_{25} =clinical performance improvement.

Alternate Hypothesis (H_a): There is a difference between management behavioral self-assessment and employee assessment of management behavior. Where, at least one variable proves to be statistically significant between management behavioral self-assessment and employee assessment of management behavior (given that all other variables remain constant).

$$H_a: \mu_1 \neq \mu_2 \neq \mu_3 \neq \mu_4 \neq \mu_5 \neq \mu_6 \neq \mu_7 \neq \mu_8 \neq \mu_9 \neq \mu_{10} \neq \mu_{11} \neq \mu_{12} \neq \mu_{13} \neq \mu_{14} \neq \mu_{15} \neq \mu_{16} \neq \mu_{17} \neq \mu_{18} \neq \mu_{19} \neq \mu_{20} \neq \mu_{21} \neq \mu_{22} \neq \mu_{23} \neq \mu_{24} \neq \mu_{25} \neq 0$$

Where μ_1 =strategic planning, μ_2 =organizational design, μ_3 =decision making, μ_4 =managing change and innovation, μ_5 =leadership, μ_6 =public law, μ_7 =medical liability, μ_8 =medical staff by-laws, μ_9 =regulations, μ_{10} =human resource management, μ_{11} =labor-management relations, μ_{12} =facilities management, μ_{13} =ethical decision making, μ_{14} =personal and professional ethics, μ_{15} =bioethics, μ_{16} =organizational ethics, μ_{17} =individual behavior, μ_{18} =group dynamics, μ_{19} =conflict management, μ_{20} =communication, μ_{21} =clinical investigation, μ_{22} =quality management, μ_{23} =quantitative analysis, μ_{24} =outcome measurements, and μ_{25} =clinical performance improvement.

Methods and Procedures

Sampling Design

The study sample derives from a total hospital staffing population of 2,301 employees. This information was pulled from the Medical Expense and Performance Reporting System (MEPRS) DS35 Personnel Report dated 10 September 2004. From the DS35 Personnel Report, the total hospital staffing population was divided into smaller population sizes comprised of 815 general schedule employees, 705 contract workers, 372 officers comprised of active duty, activated reserve and national guard officers, 345 active duty and reserve enlisted soldiers, 45 wage grade employees, and 19 volunteers (N=2,301). Two surveys were administered separately; one to a stratified random sampling taken on all hospital employees and a separate survey issued to persons serving in managerial positions. No responses from volunteer workers were sought for inclusion in the study. To ensure that survey responses were representative of the total population, the stratified random sampling was formulated by assigning desired return rates to

each of the smaller population sizes. Table 1 displays the distribution of surveys based on the stratified random sampling.

Table 1

Survey Distribution Based on Population Stratified Random Sampling

	Total Population	Survey Distribution	%
General Schedule	815	245	.30
Contract	705	71	.10
Wage Grade	45	5	.10
Officers	372	112	.30
Enlisted	345	69	.20
Volunteers	19	0	.00
	N=2,301	n=502	% Total =100
Officers			
Physicians	166	66	.40
Nurses	86	26	.30
Allied Health	45	9	.20
Medical Service	42	8	.20
Other	33	3	.10
	N=372	n=112	% Total=100

Note. All fractions of one half or greater are rounded to the next whole number.

The stratified random sampling is based upon selecting 30 percent of the general schedule employees (244.5), 30 percent of the officers (111.6), 20 percent of the enlisted soldiers (69), 10 percent of the wage grade employees (4.5), and 10 percent of the contract employees (70.5); bringing the total sample size to 502 staff members. For simplification, all fractions of one half or greater are rounded to the next whole number. To ensure that responses were representative from across the many different specialties within the officer corps, the same methodology and

stratified random sampling was applied through the subdivision of the total officer population (N=112). I selected 40 percent of the 166 physicians (66), 30 percent of the 86 nurses (26), 20 percent of the 45 allied health professionals (9), 20 percent of the 42 medical service professionals (8), and 10 percent of the remaining 33 officers (3). The 29 activated reserve and National Guard officers without an identifiable functional area in MEPRS, two chaplains, one medical maintenance warrant officer, and one United States Public Health Service officer was combined to form the remaining group of 33 officers.

A separate population for hospital management was identified (N=49). For the purposes of this study, management is defined as military officers serving in the upper stratum of hospital staff positions. The positions filled by the 49 military officers included the executive staff (i.e., Hospital Commander, and the Deputy Commanders for Clinical, Nursing, and Administrative Services), every Department Chief and Head Nurse (if a military officer was assigned), every Division Chief, and all outlying Health Clinics and Troop Medical Clinic (TMC) Chiefs as well as Head Nurses (there are three Health Clinics and three Troop Medical Clinics). Upon the identification of military officers serving in hospital management positions, the officers were withdrawn from the stratified random samplings of the total hospital staffing population, as well as officer subpopulations to avoid the duplication of survey issuance. Table 2 displays the survey distribution to military officers serving in management positions.

Table 2

Survey Distribution Based on Military Officers Serving in Upper Management Positions

	Number of Positions	Survey Distribution
Executive Staff	4	4
Clinical Departments (X20)		
Department Chiefs	20	20
Head Nurses	6	6
Administrative Divisions (X10)	10	9 ^a
Health Clinics and TMCs (X6)		
Clinic Chiefs	6	5 ^b
Head Nurses	6	5 ^c
	Total=52	N=49

^a One administrative division chief position is held by a civilian. ^b One outlying clinic chief position is held by a civilian. ^c One outlying clinic head nurse position is held by a civilian.

Research Design

This study incorporates a composite of research designs: A correlative ex post facto study design based on survey data used to discover the direction and magnitude of relationships among variables in the management population and subgroup employee sampling. The research design is a cross-sectional statistical, formal, and exploratory study based on a stratified random sampling of hospital employees and total population of military officers serving in management positions. The research is cross-sectional, focused on one moment in time, and explores to provide backing for proposed working hypotheses. Review of literature for specific measures of the attitudinal beliefs of management behavior(s) at a military treatment facility (MTF) is scarce at best, necessitating capture of stakeholder perspectives on preparedness and performance

(meeting JCAHO standards), management practices, behaviors, attitudes, beliefs, impacts on the work environment, and demographic correlation. Hence, the research is exploratory by way of seeking to determine the existence of correlations between how management views their own behavior, that of how employees view management behavioral attributes, and whether such correlation(s) are attributable to organizational productivity of a MTF. The variables used in the research are founded on the past and concurrent experiences of both hospital managers and employees, representative of an ex post facto description. Hospital management in this respect is defined as Army officers holding upper and what may be considered middle management positions (i.e., the Chiefs and Head Nurses of Departments and Divisions) in a MTF. The process of selecting research subjects, a stratified random sampling, was exacting and the statistical manipulation of research findings restricted.

The research study is descriptive in that it presents objective descriptions of research population characteristics, provides estimates of subject population characteristics, and discovers associations linking variables. In this sense, the study presents identified correlations across multiple variables. The method of proving cross-relationships seeks the common characteristic found across management attitudinal beliefs as well as the common characteristic found across employee beliefs of management behavior. To bridge the gap from construct(s) to theory, the research sets out to prove with certainty the causal relationship (central tendency) of management behavioral attributes on organizational productivity, employee beliefs, and clinical standards of patient care. Herein, a management self-assessment survey and an employee survey of management behavior were devised to test the research hypotheses.

Data Collection

Capture of respondent beliefs about essential aspects of management behavioral attributes and discovery of what attributes are significant across respondent range of knowledge was approached through the development and implementation of experience surveys as measurement instruments. Two separate data gathering instruments were administered. The first measurement instrument gathered self-assessment management behavioral data. The second measurement instrument gathered employee assessment of management behavioral data. Both survey instruments; constructed of 48 questions, seek to encapsulate the psychological and social properties associated with the behavioral attributes of medical military officers serving in hospital management positions. The first 10 questions of both surveys pertain to general demographic and/or social data descriptive of job characteristics associated with working in a military treatment facility. The remaining 38 questions in both surveys are investigative, centering on psychological properties coupled with the attitudes and beliefs of employees and managers. These 38 questions are based on the 25 out of 40 separate behavioral attributes specified by the Joint Medical Executive Skills Program as competencies expected at upper management levels. Moreover, the targeted research questions are structured to present participants with a fixed set of choices addressing the investigative nature of the study. The survey instrument design captures respondent answers through the incorporation of semantic differential and multidimensional scaling techniques, the collection of nominal, and interval data. A graphic representation of scaling methodology used to capture interval data is presented in Figure 2.

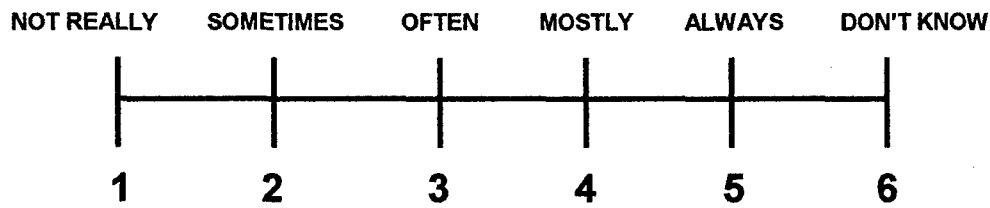


Figure 2. Hybrid Likert scaling methodology created to collect interval data.

Semantic differential was incorporated throughout the respondent questionnaire by means of modifying recognized Likert scaling. A typical Likert scaling technique captures respondent answers to survey instrument questions in the form of opinions expressed as unfavorable to favorable, never to always, methodology as measures of survey attitudinal scores. Within the scope of the survey instrument the word “no” was replaced by “not really”, here the connotative meaning of no represents the belief of behavior that is neither displayed nor witnessed. Herein, the benefit of doubt establishes that such behavior has not been totally vacated by management, yet gives respondents the opportunity to express that a particular behavior is not displayed at all, alleviating respondent socially undesirable responses, while reinforcing alternative respondent beliefs of management behavior. The same train of thought is applicable to the connotative meanings behind “sometimes”, “often”, and “mostly”, each serving subsequent levels of beliefs in displayed behaviors. Another differentiating factor from a typical Likert scale included positioning the answer choice “don’t know” at the end of the six-point scaling as opposed to a neutral response neither of agreement nor disagreement often found in the middle of variable scales; serving as a last choice in selection of attitudinal scores and thwarting development of a response set consistent with moderate answers (refer to Figure 3).

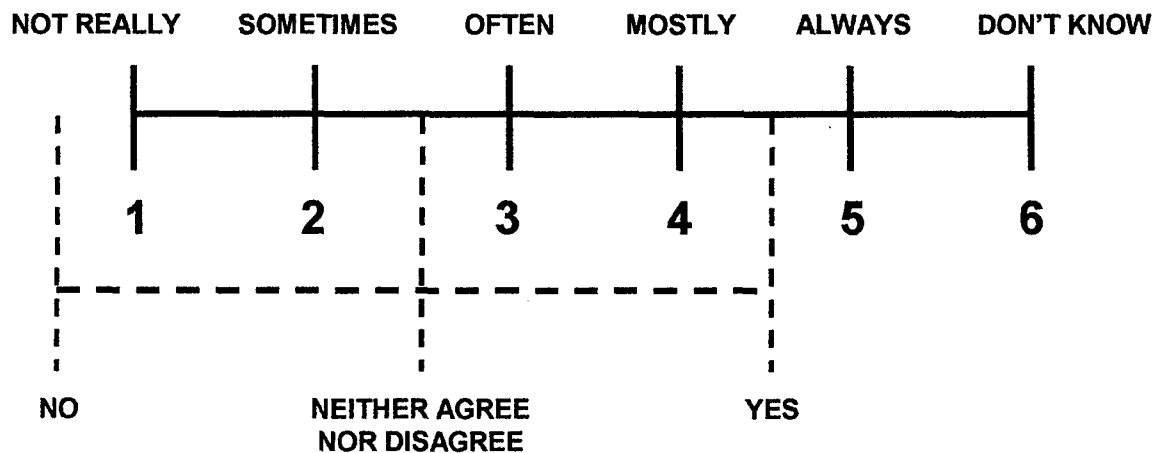


Figure 3. Comparison of hybrid Likert scaling methodology with typical scaling technique used to gather nominal data only.

Multidimensional scaling was incorporated by combining the dimensions of each respondent's rankings into a total index; followed by comparing respondent scores with the distribution of scores from within specified sample subgroups. Survey questions were created to provide respondents with the option of selecting among multiple-choice answers, but limited to a single response. No respondent selected more than one answer per question. All surveys were hand delivered to respondents in person and/or left at respondent personal workstations or personal mailbox. All surveys were collected either in person or through the hospital interdepartmental mail distribution system. Copies of the hospital staff view of management behavior and management self-assessment of own behavior surveys are provided in Appendices F and G.

Objectivity, Validity, and Reliability

The research study was approved locally by the Deputy Commander for Administration and presented before the Joint Process Improvement Committee to gain acceptance from the hospital

Executive Committee (EXCOM). The study and both behavioral assessment tools was approved and received a protocol exemption, issued by the BAMC Clinical Investigation Division, because the research design is not a true experimental study it did not have to undergo review by the Institutional Review Board (IRB). Survey objectivity follows testing of research hypotheses. During the survey development process, the scaling was devised as such to encourage participation, provoke honest answers, and affect participants to answer within the first five scale points as opposed to formulating moderating response sets by maintaining neutrality often found as a middle condition in a typical attitudinal response set (refer to Figure 3).

The hybrid Likert scale was utilized to give respondents a defined range in making a selection nearest to actual belief. The reliability of data responses was ensured through creating intervals of respondent beliefs most closely assimilated to demonstrable management behavior. Herein, categorizing the data drawn from respondent answers to attitudinal questions, based on presumed beliefs of management behavior, as interval data opposed to ordinal in determination of measurable differences between scaling points of respondent answers is corroborated in terms of Charles Osgood's Semantic Differential Theory. Charles Osgood's (1952) body of work on *semantic differentials* provided insight to the relativity of connotative meaning behind word usage in generalized circumstances. Within the limitations of this research, the issuance of scaling points were expanded from generalized three point rating scales typical of "Never, Sometimes, Always" methodologies, and coupled according to perception of meaning along the six point rating scale to more likely represent respondent beliefs. Similarly, extenuating from Charles Osgood's (1963) research *On Understanding and Creating Sentences*, the questionnaire design incorporated survey questions devoid of word associations that perpetuate respondent

answers as conditioned responses, further supporting questionnaire objectivity, validity, and reliability.

Throughout the survey design, multiple questions representative of like variables were incorporated to validate respondent answers. Both surveys incorporated repeated measures through multiple response sets of like behavioral attributes to ensure the validity of respondent answers. The reliability of respondent answers was taken into account during the sampling process. To ensure greater reliability of data input, the total population of hospital employees and management was respectively divided into subgroups, whereupon a stratified random sampling was taken from each of these subgroups to ensure appropriate distribution of survey responses from across the total population. For the purposes of the locally administered surveys, a body of 20 military and civilian health care employees and managers, varying in rank and experience, were sought to validate the surveys for content clarity, meaningfulness, and relativity. The rating scales are comprised of five to six points, inclusive of "Don't Know" as a response, ensuring categorical exhaustiveness, instilling greater specificity while retarding variant sensitivity of respondent answers. In address of the four major sources of error that contaminate research results, as presented by Cooper and Schindler (2003), the research study was designed and controlled for precise and ambiguous measurement of variables. Participant error was controlled for by ensuring early distribution of surveys during the research process in order to give respondents ample time to complete surveys without the stress of a short turnaround time. In addition, as a mechanism to control for participant error, survey participants were encouraged to complete surveys at leisure, for example, in the comfort of their home or workers lounge, uninfluenced from the pressures and distraction found in the workplace.

To promote participation as well as truthful responses to survey questions, situational error was controlled for by ensuring the complete anonymity of respondents during both survey distribution and collection. All surveys were effaced of personal identification recognizable by third parties. Respondents were assured that the coding of data into the aggregated database was also effaced of personal identification markers. Control of measurer error was handled by ensuring that data was gathered, coded, and input to the statistical database by a single recorder. All coding and statistical calculations underwent rigorous scrutiny for completeness and correctness. Acting as the sole recorder, each line of data (48 variables per line) entered into the statistical spreadsheet was checked for correctness upon initial entry and rechecked after entry. A tracking system was implemented by assigning each participant a number and then assigning each questionnaire a corresponding number; dependent upon distribution of either an employee survey or manager survey. Instituting such a questionnaire tracking system permitted ease of tracing questionnaires with irregular entries back to respondents and following up with respondents for clarification.

To control for instrument error, the lowest level of respondent education was taken into account during survey design. The lowest level of education was identified as hospital employees having attained at least a 12th grade education. Survey questions were void of all leading adjectives and ambiguities, yet not too regimented impairing respondent choice of answers. The survey design incorporated a succinct array of questions with breadth in range of answer choices to accurately capture the beliefs of managerial behavioral attributes. In response to leniency error, a total disregard for honest assessment of managerial behavioral attributes where respondents may show partiality for managers of a specific department or division, or may

try to overcompensate for the general tendency to score only high ranking positive answers, a scaling methodology of asymmetrical design was planned. The expectation is that the mean of respondent answers will closely align with "often" or "mostly" as preferred respondent choices. Herein, respondent central tendency to avoid either of opposite extremes of the scale incorporated "not really" on the far negative side and "Don't Know" found just outside "Always" on the far positive side as a technique to encourage answers more likely representative of respondent beliefs of management behavioral attributes. For example, respondents are more likely to select "Don't Know" as a choice of last resort if question response is truly unknown.

Ethical Considerations

The highest ethical standards were taken into consideration during all phases of the research process, and the study ensured complete anonymity of all survey participants. Before administering the surveys, a review of organizational, service, Department of Health and Human Service guidelines, Department of Defense (DoD), and Federal regulatory governance was conducted and abided by in accordance with Department of Defense Instruction 1100.13, *Surveys of DoD Personnel* (DoD, 1996), and Office of the Assistant Secretary of Defense for Health Affairs, *Policy for Surveys and Other Information Requirements within the Military Health System* (OASD (HA), 2000). In addition, the guidance presented in Department of Defense Directive 3216.2 (2003), *Protection of Human Subjects and Adherence to Ethical Standards in DoD Supported Research*, was followed to protect the rights and welfare of participants possibly affected by the research. Careful consideration was especially made to safeguard the identity of respondents, thereby minimizing associated risk of repercussions from management seeking acts of reprisal against employee respondents, in turn encouraging

participation. No inducement for participation was made or offered. Through the course of the research study and survey implementation, no deception was made affecting respondent willingness to participate.

To minimize intrusion on respondent privacy, participants were informed of their right to participate, right to refuse to answer any question, and access to participant identification was restricted solely to the researcher. Study participation was voluntary with the understanding that the survey offered no direct benefit to participants other than knowing that research results offered feedback to hospital management targeting required/needed training or counseling; counseling coming in many forms (i.e., in relation to organizational or clinical performance, behavior modification, etc.). In addition, the scope of this research may lead to future studies of specific behavior modifications that will maximize organizational effectiveness. Safeguards taken to protect the identity of research subjects included researcher maintaining ownership of questionnaires and personal safeguard of all records. The questionnaires were effaced of personal identifying responses, individual unique data, traceable back to the respondent. The confidentiality of respondent opinions and beliefs was maintained through the reinforcement with respondents to neither sign nor annotate personal identification on the survey and return envelopes.

All surveys were distributed in person and either collected in person or through the hospital's mail system using interdepartmental distribution envelopes with return address to the researcher. A few respondents went so far as to return surveys in sealed nondescript envelopes rather than the interdepartmental distribution envelope provided. Relying solely on researcher distribution and retrieval of surveys further assured participant confidentiality. Immediately following data

collection, the single hardcopy spreadsheet with by name sample created in support of tracking respondent participation was shredded and all digital spreadsheets created with respondent identifiers were deleted from the researcher's secure personal computer. All collected data was recorded into SPSS without respondent identifiers further ensuring the anonymity of research subjects. All respondent answers were consolidated and only group data was reported. No improper sharing of participant answers or embellishment of research findings were passed on during consultation with colleagues. No one outside the surveyor knew of the responses given by employees or management. All surveyed persons serving in management positions, as well as employee respondents inquisitive of research findings, were provided a copy of the graduate management project.

Data Analysis

In order to simplify running multiple stratified random samplings on officers and subgroups of employee populations, the MEPRS data was imported into an *Excel* format that came standard with *Microsoft Office 2000 (SR-1 Professional)*, whereupon the total hospital population was then stratified into separate *Excel* worksheets based on target subgroup populations of officers, federal service employees, enlisted soldiers, and contract workers. The random samplings were calculated using the "Paste" and "RAND" functions, found within *Excel* tools, upon which random numbers were generated. Separate parametric statistics (descriptive and inferential) was employed to measure association and significance within survey data. The *Statistical Package for the Social Sciences* (SPSS) version 12.0 for *Windows* was utilized to analyze all quantitative data, expressed as descriptive, correlational, and regression statistics. Descriptive statistics was used to summarize data and measure central tendency. To test the significant differences

between the means of group variables on the two dependent variables (management and employee beliefs) considered simultaneously, a multivariate analysis of variance (MANOVA) was employed. Two-way analysis of variance (ANOVA) was employed to test for significant interactions (association) within sets of independent variables considered simultaneously. Cronbach's alpha was utilized to ensure instrument reliability of data, or consistency in results, and predictive validity.

Analysis and Results

The results of the survey distribution response rates are presented in Table 3. Five hundred and fifty one surveys were distributed throughout the Fort Hood health system, to include the Darnall military treatment facility, six outlying health clinics, community health, occupational health, refill pharmacy, preventive medicine, social work services, psychology, substance abuse rehabilitation, blood donor center, pediatric clinic, and satellite administrative locations. The total number of surveys distributed to the hospital employee sample was 225 with a response rate of 45%. Out of the 225 surveys distributed to the hospital employee sample, 61 surveys were returned unanswered (12%) because these persons moved with military spouse or left for a better paying job (16), changed duty stations (12), were deployed in support of Operation Iraqi Freedom (10), released from active duty (5), fulfilled only part time employment (4), were fired or quit (4), medically retired (3), chaptered out of the Army (2), ended their term of service (2), placed on permanent administrative leave (2), or retired (1). The number of surveys distributed to military officers serving in management positions totaled 49 with a response rate of 57%. The lowest return rates by population subgroup came from Army nurses at 27% followed by Army physicians at 29%; all remaining subgroup response rates were 35% or greater. The highest

response rates by population subgroup came from wage grade civilians at 100% and other military officers (e.g., warrant, chaplain, reserve branch unidentified) at 100%. The initial impression of 100% return rates appears incredible, but taking into account that 10% of either of the total populations for these groups amounted to extremely low sample sizes. The return rates by subgroup for military officer management ranged from a low of 40% and a high of 75%.

Table 3
Survey Distribution Response Rates

<u>Employee Sampling</u>			
Total Sample	n = 502		
	<u>Distributed</u>	<u>Returned Completed</u>	<u>%</u>
General Schedule	245	127	.52
Contract	71	25	.35
Wage Grade	5	5	1.0
Officers	112	41	.37
Enlisted	69	27	.39
Total = 502		Total = 225	Return Rate = 45%
	<u>Distributed</u>	<u>Returned Completed</u>	<u>%</u>
Officers			
Physicians	66	19	.29
Nurses	26	7	.27
Allied Health	9	5	.56
Medical Service	8	7	.88
Other	3	3	1.0
Total = 112		Total = 41	Return Rate = 37%
<u>Management Sampling</u>			
Total Sample	N = 49		
	<u>Distributed</u>	<u>Returned Completed</u>	<u>%</u>
Executive Staff	4	3	.75
Department Chiefs	20	12	.60
Department Head Nurses	6	3	.50
Division Chiefs	9	6	.67
Clinic Chiefs	5	2	.40
Clinic Head Nurses	5	2	.40
Total = 49		Total = 28	Return Rate = 57%

Note. All fractions of one half or greater are rounded to the next whole number.

To check the internal consistency of the survey instruments, Cronbach's alpha coefficient test was employed. The reliability measure of Cronbach's alpha found both the Hospital Staff View of Management Behavior Survey (.897) and the Management Self-Assessment Survey of Own Behavior (.916) to be highly reliable assessment instruments. The means and standard deviation results of participant responses are presented in Table 4 (Management Descriptive Statistics) and Table 5 (Employee Descriptive Statistics). To ease interpretation of coded variables refer to Appendix B, Methodology for Operationalizing Variables, Measures, and Coding of Data. The mean age for hospital employees was between 37 and 41 years of age, whereas the mean age of management was between 42 and 47 years of age. First glance of pay grade reveals that there is a drastic disparity between the mean responses of employees (9.7022) and the mean responses of management (2.1786), but in comparing the variances of the two, the variance for employee pay grade is 100 times the variance of management pay grade. The mean for military status implies that the average civilian employee is retired military and the mean for military officer management, as expected, is active duty. The mean education level for hospital employees is at the Associate Degree level and length of federal service was between seven and ten years.

In comparison, management mean for education level was having achieved a Master's Degree or higher and length of federal service was greater than 15 years. As expected, age of hospital management is closely related with level of education and length of federal service. All three of these variables coincide with each other, steadily increasing in number of years along approximate similar paths, less released from the military. The remaining participant responses to beliefs of management behavioral attributes are in close proximity along the hybrid Likert scale. For example, the mean of responses given by hospital employees are aligned with the

response choice of "often" and the mean of responses given by hospital management is aligned with the response choice of "mostly" (mean scores are rounded to the next whole number). The point to take away, is that although both mean response sets are closely associated, the mean of responses given by employees and management are not the same, the primary difference being that the mean employee responses do not equate management doing as good a job as self-assessed.

Table 4
Management Descriptive Statistics

	N	Mean		Std.	Variance
	Statistic	Statistic	Std. Error	Statistic	Statistic
Gender	28	1.5000	.09623	.50918	.259
Age	28	6.0714	.21162	1.11981	1.254
Ethnicity	28	2.7143	.12448	.65868	.434
Pay Grade	28	2.1786	.08988	.47559	.226
Military Status	28	1.0714	.04956	.26227	.069
Highest Education Level	28	5.9643	.03571	.18898	.036
Length of Federal Service	28	5.6786	.13660	.72283	.522
Length of Service at Damall	28	2.0714	.16207	.85758	.735
Level of Work	28	2.0000	.19245	1.01835	1.037
Classification of Primary Function	28	2.3929	.28794	1.52362	2.321
Strategic Planning	28	3.2857	.13469	.71270	.508
Organization Design	28	2.8214	.19282	1.02030	1.041
Decision Making	28	4.1786	.19282	1.02030	1.041
Change and Innovation	28	3.0714	.17003	.89974	.810
Change and Innovation2	28	4.2500	.20972	1.10972	1.231
Leadership	28	3.9643	.17429	.92224	.851
Leadership2	28	2.9286	.15369	.81325	.661
Leadership3	28	4.1786	.16309	.86297	.745
Law and Policy	28	4.8214	.10356	.54796	.300
Law and Policy2	28	4.5357	.21506	1.13797	1.295
Law and policy3	28	4.4286	.16610	.87891	.772
Resources Allocation	28	4.6071	.14853	.78595	.618
Resources Allocation2	28	4.1071	.19477	1.03062	1.062
Resources Allocation3	28	4.2143	.17334	.91721	.841
Resources Allocation4	28	4.6786	.13660	.72283	.522
Resources Allocation5	28	4.0714	.17003	.89974	.810
Resources Allocation6	28	2.6786	.14596	.77237	.597
Ethics	28	4.6429	.10559	.55872	.312
Ethics2	28	4.8571	.06734	.35635	.127
Ethics3	28	4.7143	.14417	.76290	.582
Ethics4	28	4.7857	.09424	.49668	.249
Individual and Organization Behavior	28	4.1071	.20145	1.06595	1.136
Individual and Organization Behavior2	28	4.2500	.15957	.84437	.713
Individual and Organization Behavior3	28	3.9643	.18886	.99934	.999
Individual and Organization Behavior4	28	4.0714	.16207	.85758	.735
Individual and Organization Behavior5	28	4.1429	.15183	.80343	.646
Individual and Organization Behavior6	28	4.3571	.16438	.86984	.757
Individual and Organization Behavior7	28	4.4286	.14019	.74180	.550
Individual and Organization Behavior8	28	4.0000	.17817	.94281	.889
Individual and Organization Behavior9	28	3.7143	.13469	.71270	.508
Individual and Organization Behavior10	28	4.0714	.20528	1.08623	1.180
Individual and Organization Behavior11	28	4.3214	.16309	.86297	.745
Individual and Organization Behavior12	28	3.8929	.17320	.91649	.840
Individual and Organization Behavior13	28	4.0000	.22420	1.18634	1.407
Individual and Organization Behavior14	28	4.5714	.11984	.63413	.402
Safety	28	3.5357	.25964	1.37389	1.888
Safety2	28	3.3571	.14741	.78004	.608
Safety3	28	3.5714	.16610	.87891	.772
Valid N (listwise)	28				

Table 5
Employee Descriptive Statistics

	N	Mean		Std.	Variance
	Statistic	Statistic	Std. Error	Statistic	Statistic
Gender	223	1.6592	.03181	.47505	.226
Age	223	5.4036	.12057	1.80050	3.242
Ethnicity	223	2.6457	.07480	1.11705	1.248
Pay Grade	223	9.5291	.32798	4.89786	23.989
Military Status	223	3.4933	.11314	1.68958	2.855
Highest Education Level	223	4.1614	.08506	1.27022	1.613
Length of Federal Service	223	4.4036	.10633	1.58779	2.521
Length of Service at Darnall	223	3.1883	.11174	1.66859	2.784
Level of Work	223	5.2377	.14868	2.22030	4.930
Classification of Primary Function	223	4.0493	.11793	1.76101	3.101
Strategic Planning	223	3.5426	.07011	1.04697	1.096
Organization Design	223	2.9148	.07698	1.14958	1.322
Decision Making	223	3.5067	.09382	1.40100	1.963
Change and Innovation	223	3.0269	.08236	1.22995	1.513
Change and Innovation2	223	2.9238	.10087	1.50630	2.269
Leadership	223	2.9417	.09663	1.44297	2.082
Leadership2	223	2.8430	.08084	1.20716	1.457
Leadership3	223	3.0000	.09341	1.39497	1.946
Law and Policy	223	3.8475	.10681	1.59506	2.544
Law and Policy2	223	4.4933	.08941	1.33515	1.783
Law and policy3	223	4.4798	.08135	1.21488	1.476
Resources Allocation	223	2.9238	.11098	1.65723	2.746
Resources Allocation2	223	2.9058	.09857	1.47199	2.167
Resources Allocation3	223	2.8206	.09876	1.47475	2.175
Resources Allocation4	223	4.1211	.10914	1.62986	2.656
Resources Allocation5	223	3.8744	.08021	1.19775	1.435
Resources Allocation6	223	3.0269	.06322	.94402	.891
Ethics	223	3.6592	.09386	1.40157	1.964
Ethics2	223	3.8072	.09306	1.38965	1.931
Ethics3	223	4.6009	.08498	1.26896	1.610
Ethics4	223	4.0762	.08595	1.28348	1.647
Individual and Organization Behavior	223	2.4439	.10060	1.50232	2.257
Individual and Organization Behavior2	223	2.5516	.09311	1.39037	1.933
Individual and Organization Behavior3	223	2.7265	.09870	1.47397	2.173
Individual and Organization Behavior4	223	3.1435	.09335	1.39402	1.943
Individual and Organization Behavior5	223	3.3991	.10342	1.54436	2.385
Individual and Organization Behavior6	223	3.4081	.11208	1.67368	2.801
Individual and Organization Behavior7	223	3.3498	.10942	1.63398	2.670
Individual and Organization Behavior8	223	3.6951	.11953	1.78490	3.186
Individual and Organization Behavior9	223	2.7354	.07238	1.08094	1.168
Individual and Organization Behavior10	223	3.0942	.10833	1.61778	2.617
Individual and Organization Behavior11	223	4.0762	.12257	1.83031	3.350
Individual and Organization Behavior12	223	4.1928	.12032	1.79678	3.228
Individual and Organization Behavior13	223	3.7578	.11745	1.75392	3.076
Individual and Organization Behavior14	223	4.1794	.08370	1.24991	1.562
Safety	223	4.1784	.09731	1.45321	2.112
Safety2	223	3.7265	.04847	.72383	.524
Safety3	223	2.8475	.06828	1.01966	1.040
Valid N (listwise)	223				

A highlight of the demographic frequency distribution of employee responses entailed 148 females (65.8%), 77 males (34.2%), 18.7% fell in the 48 to 53-age bracket and another 18.7% fell in the 42 to 47 age bracket. One hundred and three employees (45.8%) are Caucasian followed by 68 African Americans (30.2%). Fifty employees (22.2%) fell in the GS01 to GS05 pay grade followed by 49 employees (21.8%) falling in the GS06 to GS 09 pay grade. Sixty-two employees (27.6%) were active duty while another 103 employees (45.8%) had no prior military experience. Seventy employees (31.1%) have some college education followed by 51 employees (22.7%) with Associate Degrees and another 50 employees (22.2%) with Master Degrees or higher levels of education. Eighty-six employees (38.2%) have over 15 years in the Federal Civil Service and 77 employees (34.2%) have been working at Darnall Army Community Hospital for one to three years, while another 35 employees (15.5%) have been working at Darnall for over 15 years. The frequency distributions of hospital employees are presented in Table 6, Appendix C.

In comparison, the demographic break down of responses from hospital military officers serving in management positions consisted of 14 male (50%) and 14 female (50%), 4.9% of managers fell in the 42 to 47 age bracket and 28.6% fell in the 48 to 53 age bracket. Twenty-three managers (82.1%) identified themselves as Caucasian, while 10.7% identified themselves as Hispanic. Twenty-one managers (75%) were in the pay grade of O4 to O5 and 21.4% were in the pay grade of O6. Twenty-six managers (92.9%) are active duty officers and another 7.1% identified themselves as activated Guard or Reserve officers. Twenty two managers (96.4%) have a Master Degree or higher level of education, 22 managers (78.6%) have over 15 years of federal service, and 50% have been stationed at Darnall Army Community Hospital for the past

one to three years. The frequency distributions of hospital management are presented in Table 6, Appendix C.

In addition, Table 6, Appendix C presents the core competency response frequencies for hospital employees and management. A highlight of comparative core competency responses between employees and management are based on participant beliefs of how well management addresses each competency. Employees (42.2%) and management (42.9%) agreed that managers place a moderate degree of emphasis on strategic planning; the other 42.9% of management believed a high degree of emphasis is placed on strategic planning. Employees (41.8%) and half of management (50%) agreed that the hospital is moderately structured to perform its mission. Employees (34.2%) believe that management for the most part make decisions that support the hospital, whereas the majority of management (53.6%) believed that they always make decisions that support the hospital. Employees (24.9%) and the majority of management (53.6%) believed that the hospital was moderately changing to support future demands. Employees (22.7%) and management (25%) believed that the hospital was minimally changing to support future demands.

Employees responded that they are encouraged sometimes (24.9%) and not really (21.8%) to be creative and inventive. Management responded that they always (64.3%) and often (17.9%) encourage employees to be creative and inventive. Employees responded that management sometimes (30.2%) and mostly (26.7%) utilizes appropriate leadership and management techniques. Management responded that they mostly (39.3%) and always (32.1%) utilize the appropriate leadership and management techniques. Employees responded that supportive (36.9%) and participative (22.2%) best describes their immediate supervisor's leadership style.

Similarly, management responded that participative (46.4%) and split between supportive (25%) and achievement oriented (25%) best described their leadership style. Employees (37.3%) responded that there is mostly a positive organizational climate, culture, and trust among staff, whereas management (46.4%) responded that they mostly create such an environment. Employees split between always (25.3%) and mostly (25.3%) in their response to identification of violations of unlawful actions and appropriate actions taken. Management (78.6%) responded that violations of unlawful actions and that appropriate actions are taken always.

Employees (24.4%) responded that they are sometimes afforded opportunities for training, professional growth and development. Another 21.3% of employees responded that they are not really afforded such opportunities. Management (46.4%) responded that they always afford opportunities for training, growth and professional development. Employees (28.9%) responded that the command climate for the most part promotes a high level of morale and job satisfaction, whereas 46.4% of management responded that they always promote such a command climate. The majority of employee (38.2%) and management (42.9%) responses believed that the condition of the hospital was adequate, but needed minor improvement. The majority of employee responses (35.1%) believed that hospital leaders display both personal and professional ethical behavior most of the time, whereas the majority of management responses (85.7%) believed they always display such ethical behavior. The majority of both employees (35.1%) and management (85.7%) responded that incidents involving harm or have the potential to harm a patient are always reported.

Employees responded (36.9%) that they are not really coached or mentored by hospital leadership. Conversely, management responded (50%) that they always coach and mentor

hospital employees. Employees responded (33.8%) that hospital leadership sometimes motivates others through effective communication, reinforcement, recognition, and/or reward. The majority of management responses were evenly split between always (35.7%) and mostly (35.7%) motivating employees through effective communication, reinforcement, recognition, and/or reward. The majority of employee (26.7%), closely followed by 25.8% for sometimes, and management (50%) responded that hospital leaders for the most part clearly define and articulate goals, tasks, purposes, and parameters. Employees (26.7%) responded that hospital leadership for the most part develop an organizational climate in which groups can openly deliberate and report findings without fear of reprisal. Management (53.6%) responded that they always foster such an organizational climate.

Employees (27.1%) responded that they did not know if hospital leadership employed best business and practice guidelines to enhance organization performance. Management (39.3%) responded that for the most part they do employ best business and practice guidelines to enhance organization performance. The majority of employee (28%) and management (28.6%) responded that the hospital for the most part does have an effective patient safety and risk management program. Lastly, employees (33.8%) responded that they have a high degree of trust in hospital leadership to make appropriate changes in the work environment. Management (28.6%) responded that hospital employees have a high degree of trust in them to make appropriate changes in the work environment. Conversely, employees (29.8%) responded that they did not know if they could trust hospital leadership to make appropriate changes, and management (64.3%) responded that they did not know if hospital employees trusted them.

Having identified the frequency distributions of employee and management responses, the affects of specified management behavioral attributes were targeted for significance testing. Each management self-assessment response score was treated as a separate and unique management behavioral attribute (independent variables). Employee responses were treated as separate and unique beliefs dependent upon management behavior. Based on analysis of variance testing, the factor of management's ability to make decisions that support the hospital on employee beliefs that all incidents that involve harm or have the potential to harm a patient is positively affected by management's personal and professional ethics, $F(3, 24) = 5.338, p = .006$. Management's ability to make decisions that support the hospital accounted for variance in employee belief that leadership for the most part does develop an organizational climate in which groups can openly deliberate and report findings without fear of reprisal, $F(3, 24) = 6.692, p = .002$. The factor of management's behavior in a changing environment was reflected positively on employee beliefs that management for the most part employs tools and techniques to aid in risk analysis and reduction, $F(3, 24) = 3.445, p = .033$. Management's emphasis on encouraging hospital staff to be creative and inventive was supported by employee beliefs that for the most part management does develop a positive organizational climate, $F(3, 24) = 4.159, p = .017$, but were uncertain of management soliciting and incorporating feedback, ideas, comments, and suggestions from others, $F(3, 24) = 3.220, p = .041$.

The factor of management leadership style is highly positive with employee beliefs that all incidents involving harm or have the potential to harm a patient are always reported, $F(3, 24) = 4.002, p = .019$. The management factor of creating a positive organizational climate, culture, and trust is positively validated along with employees believing that incidents of harm or

possibly harming a patient are reported, $F(3, 24) = 3.946$, $p = .020$. The factor of management addressing potential liability issues and to take actions to prevent claims against the hospital, accounted for variance in employee belief that incidents involving harm or have the potential to harm a patient are always reported, $F(4, 23) = 5.752$, $p = .002$. The factor of management assessing current staffing levels against the needs of the hospital, proved positively significant in concert with employee beliefs that management always follows medical by-laws, policies, and regulations, $F(3, 24) = 3.544$, $p = .030$. In addition, management's assessment of staffing levels showed a significant relationship with employee beliefs that management for the most part do emphasize involvement, empowerment, and encouragement toward employees to continuously learn and reengineering efforts, $F(3, 24) = 7.523$, $p = .001$.

The factor of management behavior to promote opportunities for employee training, professional growth, and development is validated by employee beliefs that management for the most part distinguish between right and wrong conduct, $F(3, 24) = 3.701$, $p = .025$. Management behavior to promote training and professional development of employees exhibited significance in concert with employee beliefs that all incidents involving harm or have the potential to harm a patient is reported, $F(3, 24) = 14.873$, $p = .000$, and within employee beliefs of counseling frequency, $F(3, 24) = 4.005$, $p = .019$. To view the analysis of variance significant results with repeated measures in its entirety, refer to Table 9, Appendix D. Statistical testing for covariation and significant relationships of management behavior on employee beliefs proved consistent with acceptance of the alternate hypothesis; significant relationships are confirmed between management behavior affects on employee attitudes and beliefs about management behavioral attributes.

Discussion

Implications

The greatest divergence between hospital employee beliefs of management behavior and management self-assessment stems from the core competency of individual and organizational behavior. The implications of this type of study can be applied to other measurable organizational outcomes. In the health care industry, management behavior studies can be used to look at the effectiveness and efficiency in hospitals with a focus on changes in the health status of hospital beneficiary population (e.g., preventative service outcomes, infection control rates, adverse drug events, morbidity, and mortality rates). The utility of the management behavior assessment tool offers executives and managers an introspective report card of organization executive skill set competencies. Likewise, the employee assessment tool of management behavior presents a portal by which managers gain a better understanding of employee attitudes and beliefs, as well as insight to own behavioral attributes. The management behavior assessment tools, accessible through a shared website by all branches of the military health system (MHS), are administrable across all military medical treatment facilities; giving the Joint Medical Command visibility of specific behavioral skills that need refinement through sponsored training and development. The method of study posits the basis for a more precisely controlled longitudinal study across multiple medical activities purporting the prediction of causal relationships between management and employee assessments of behavioral attributes.

Assumptions and Limitations

Based on the research findings it is safe to assume that employee and management beliefs of management behavior are contextually associated, demonstrable through formulation of

significant relationships. Within the constructs of this study, senior management are expected to perform at higher levels of performance and are more likely to be highly regarded in comparison to middle management. This assumption is based on years of experience, commensurate with rank, level of civilian education, and exclusivity of training. Conversely, younger and less experienced managers tend to regard the work environment within negative connotations, but tend to display higher levels of motivation and organizational commitment. Herein, younger managers, given the chance to excel, will perform at higher levels. Senior managers are assumed to display the best management practices, as well as behave in more generally acceptable conduct. Survey construction is nearly identical for both management self-assessments and employee beliefs of management behavior. Therefore, it is presumed that there should be little to no difference between employee and management beliefs of management behavioral attributes. Initial perception suggests that employee beliefs should prove comparatively similar and/or maintain agreeance with the beliefs of management. Likewise, statistical outcomes should prove that at least one or more measured variables are closely related.

The greatest limitation associated with this project was time. Although this research study was exploratory in nature and required completion within a one-year timeframe, a more fortuitous research study of human behavior would be best executed in phases over a number of years. Additional limitations associated with this body of research include responses from small sample sizes of subpopulation groups that were disproportionate in comparison to the responses from larger military and civilian sample sizes. Survey assessments have the potential for random or systematic error posing the possibility to underestimate and/or overestimate the true values of the survey. Reactivity of measurement is endemic within behavioral studies making data

reliability problematic. The management behavioral assessment instrument is limited to respondent answers based on the connotative meaning of adjectives used in the scaling methodology. Whereas, open-ended questions within survey designs offer clarification of respondent answers. Despite controlling for respondent and instrument error, participants that give socially desirable answers and/or participants that develop response sets cannot be controlled for given every environmental condition. Likewise, general attitudes on any given day toward work or home related stressing issues might prove problematic. Self-administered questionnaires saved time during the implementation phase of distribution, as well as using the hospital mail distribution system to collect the surveys, but increase the potential for respondent error. Whereas, issuing surveys under a controlled research environment and/or through the conduct of one-on-one interviews offers the greatest control for respondent error. In addition, this type of study lends itself to survey bias by workers fearing retribution, recall bias, and/or management's own inability to answer non-objectively.

Recommendations

There is just cause for conducting a longitudinal study based on three phases of execution. The first phase concerns development of the behavior assessment instrument, validation of that instrument, instrument implementation, data gathering, and analysis of findings. Upon arriving at conclusions, the second phase concerns identification of behavior modification methods, tools, and techniques, selection of a behavior modification method, and its implementation throughout the respondent population. The third phase concerns reassessing the respondent population to observe for change effects in the modified behavior and report of findings. The scope of this

research may lead to future studies of specific behavior modifications that will maximize organizational effectiveness.

Conclusions

McConnell (2003) posits that employees' willingness to follow and support the direction of management is indicative of successful management behavior. Regardless of self-serving management behavior, as long as the goals of employees are satisfied, organizational objectives will be achieved. As managers dependably adjust their own behavior in support of organizational objectives, employees are more likely involved in change processes, empowered to make decisions, and are encouraged to be innovative. Managers exhibit responsible tendencies when self-assessed, but demonstrate a higher order of responsibility when accepting of employee assessments of management behavior.

Appendix A
Terms Defined

federal civil service employees	Civilians employed by the United States Federal Government serving in positions that vary in pay according to skill type and number of years employed (e.g., general schedule).
management (positions)	Defined to include the responsible officials and their assistants at the division, branch, section, and comparable level and above, for both operating and staff and service functions (DoD, 1971).
military health system (MHS)	The military equivalent to a civilian health system encompassing emergency, trauma, inpatient and outpatient medical service facilities, as well as optometry, preventive medicine, and veterinary services.
medical activity (MEDDAC)	The military equivalent to a medium sized civilian hospital (may or may not include inpatient medical services). Also, a military treatment facility (MTF).
Level Three Trauma	Level Three Trauma is determined by a hospital's capability to care for all major and severe trauma patients 24 hours per day, seven days per week, rarely diverting such patients to other facilities.
performance and productivity	Defined as a state of readiness in anticipation of providing medical services and associated measurable characteristics (e.g., clinical standards of patient care).
Global War on Terrorism (GWOT)	The GWOT arose from the terrorist attacks on the Pentagon and World Trade Center. It is the military objective to rid terrorism from around the world.

Appendix A continued
Terms Defined

strategic planning	Is the organizational process of assessing situations, establishing direction, and executing goals in support of mission requirements (JMESP, 2003).
organizational design	Is the configuration of the hospital design elements (i.e., people, organizational structure, tasks, technology, and mission/values) for efficiency and effectiveness (JMESP, 2003).
decision making	Is the process of selecting courses of action from alternatives (JMESP, 2003).
change and innovation	Is the opportunity to shape the future of the hospital (JMESP, 2003).
leadership	Is the art and science of influencing others to accomplish the mission (JMESP, 2003).
public law	Are the laws that specify the requirements for public health, patient consent/rights, and environmental standards (JMESP, 2003).
medical liability	Is tort and criminal offenses that may incur risk to the hospital or providers (JMESP, 2003).
medical staff by-laws	Outline the conduct and privileges of the medical staff IAW JCAHO standards (JMESP, 2003).
Regulations	Includes all Federal, DoD, state, and local guide lines that affects the operation of the hospital (JMESP, 2003).
human resource management	Includes the staffing, management, and retention of personnel (JMESP, 2003).
labor-management relations	Is the interaction between hospital management and civilian staff (JMESP, 2003).

Appendix A continued

Terms Defined

facilities management	Is the maintenance and upkeep of real property, such as a building, structure, or utility system (JMESP, 2003).
ethical decision making	Consists of the processes, structures, and social constructs by which the rightness or wrongness of actions is assessed (JMESP, 2003).
personal and professional ethics	Is the professional code of ethics representing the morality of an individual or a group of persons with regard to their professional roles (JMESP, 2003).
bioethics	Represents the application of ethics to the life sciences, including medicine and associated research (JMESP, 2003).
organizational ethics	Describes the structures and processes by which an organization ensures conduct appropriate to its mission and vision (JMESP, 2003).
individual behavior	Is the effect of the commander's behavior and personality on the hospital (JMESP, 2003).
group dynamics	Is the interaction among members of a group (JMESP, 2003).
conflict management	Involves the identification and use of techniques to effectively manage interpersonal, group, and organizational conflicts (JMESP, 2003).
communication	Is when the receiver understands the sender's intended message (JMESP, 2003).
clinical investigation	Encompasses the acts surrounding the initiation, performance, completion, publication, and use of research (JMESP, 2003).
quality management	Encompasses the procedures that emphasize involvement, empowerment, and continuous performance improvement (JMESP, 2003).

Appendix A continued
Terms Defined

quantitative analysis	Ensures that information is available for decision making through the use of analytical tools and methodologies to collect, organize, arrange, analyze, interpret, and evaluate data (JMESP, 2003).
outcome measurements	Permit the hospital commander to make fact-based decisions (JMESP, 2003).
patient safety	Involves all those activities to minimize the risk of medical error, including developing a program and establishing a command climate to proactively identify and reduce potential risks to patients (JMESP, 2003).

Appendix B
Methodology for Operationalizing Variables, Measures, and Coding of Data

INDEPENDENT VARIABLE & SPSS CODE	DESCRIPTION	SPSS DATA CODE
GENDER	What is your gender?	MALE=1, FEMALE=2
AGE	What is your age range?	17-20=1, 21-25=2, 26-31=3, 32-36=4, 37-41=5, 42-47=6, 48-53=7, 54>=8
RACE	What is your ethnic background?	CAUCASIAN=1, AFRICAN AMERICAN=2, HISPANIC=3, ASIAN PACIFIC ISLANDER=4, NATIVE AMERICAN=5, OTHER=6
GRADE	What is your pay grade?	O1-O3=1, O4-O5=2, O6>=3, E-1-E4=4, E-5-E6=5, E7-E8=6, E9=7, CWO1-WO2=8, WO3-WO4=9, WO5=10, GS01-GS05=11, GS06-GS09=12, GS10-GS12=13, GS13>=14, WAGE GRADE=15, CONTRACT CIVILIAN=16, Other=17
MILITARY STATUS (MS)	What is your military status?	ACTIVE DUTY=1, ACTIVATED GUARD/RESERVE=2, RETIRED MILITARY=3, SOME PRIOR SERVICE EXPERIENCE=4, N/A=5
EDUCATION (ED)	What is the highest education level attained?	HIGH SCHOOL=1, HIGH SCHOOL GRAD OR EQUIVALENT=2, SOME COLLEGE=3, ASSOCIATES=4, BACHELORS=5, MASTERS OR HIGHER=6
LENGTH OF FEDERAL SERVICE (LOS)	How long working for the federal government?	<1 YEAR=1, 1-3 YEARS=2, 4-6YEARS=3, 7-10 YEARS=4, 10-15 YEARS=5, >15 YEARS=6, N/A=7
LENGTH OF SERVICE AT DARNALL (LOSD)	How long working at Darnall Army Community Hospital?	<1 YEAR=1, 1-3 YEARS=2, 4-6YEARS=3, 7-10 YEARS=4, 10-15 YEARS=5, >15 YEARS=6
LENGTH OF SERVICE AT DARNALL (LOSD)	How long working at Darnall Army Community Hospital?	<1 YEAR=1, 1-3 YEARS=2, 4-6YEARS=3, 7-10 YEARS=4, 10-15 YEARS=5, >15 YEARS=6
FUNCTION (FTN)	What level of work were you hired to perform?	SENIOR MANAGEMENT=1, MIDDLE MANAGEMENT=2, SUPERVISORY=3, PROFESSIONAL=4, PARAPROFESSIONAL=5, ADMINISTRATOR=6, TECHNICAL=7, CLERICAL=8, LABOR=9, OTHER=10
FTN2	What classification describes your primary function?	PHYSICIAN=1, NON-PHYSICIAN PROVIDER=2, ADMINISTRATOR=3, MEDICAL TECHNICIAN OR ASSISTANT=4, MEDICAL THERAPIST OR TECHNOLOGIST=5, OTHER=6

Appendix B continued
Methodology for Operationalizing Variables, Measures, and Coding of Data

STRATEGIC PLANNING(STRAT)	What degree of emphasis is placed on the hospital strategic plan?	NONE=1, LOW DEGREE=2, MODERATE DEGREE=3, HIGH DEGREE=4, DON'T KNOW=5
ORGANIZATION DESIGN (ORGD)	Is the hospital structured to perform its mission?	NOT REALLY=1, MINIMALLY=2, MODERATELY=3, HIGHLY=4, DON'T KNOW=5
DECISION MAKING (DECMK)	Are decisions made that supports the hospital?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
CHANGE AND INNOVATION (CHGINN)	Is the hospital changing to meet future demands?	NOT REALLY=1, MINIMALLY=2, MODERATELY=3, HIGHLY=4, DON'T KNOW=5
CHGINN2	Are hospital staff encouraged to be creative and inventive?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
LEADERSHIP (LDRSHP)	Do hospital leaders use appropriate leadership and management techniques?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
LDRSHP2	What leadership style best characterizes your immediate supervisor?	AUTHORITATIVE/DICTATORIAL=1, SUPPORTIVE/EMBRACING=2, PARTICIPATIVE/ENGAGING=3, ACHIEVEMENT/GOAL ORIENTED=4, ABSENCE OF LEADERSHIP=5
LDRSHP3	Is there a positive organizational climate, culture, and trust among staff?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
LAW AND POLICY (LAP)	Are violations of unlawful actions identified and appropriate actions taken?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
LAP2	Are potential liability issues addressed and actions taken to prevent malpractice claims?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
LAP3	Does hospital leadership follow medical by-laws, policies, and regulations?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
RESOURCES ALLOCATION (RESALL)	Are current staffing levels assessed against needs and/or projected requirements?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6

Appendix B continued
Methodology for Operationalizing Variables, Measures, and Coding of Data

RESALL2	Are opportunities for training, professional growth, and development afforded employees?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
RESALL3	Does the command climate promote a high level of morale and job satisfaction?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
RESALL4	Do hospital leaders follow proper labor relation procedures?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
RESALL5	Does hospital leadership ensure the proper upkeep and maintenance of the facility?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
RESALL6	What is the present condition of the hospital?	POOR/FAILING=1, NEEDS MODERATE IMPROVEMENT=2, ADEQUATE/NEEDS MINOR IMPROVEMENT=3, GOOD=4, GREAT=5
ETHICS	Does hospital leadership distinguish between the rightness vs. the wrongness of conduct?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
ETHICS2	Do hospital leaders display both personal and professional ethical behavior?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
ETHICS3	Are all incidents that involve harm or have the potential to harm a patient reported?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
ETHICS4	Do hospital leaders promote a culture and climate that supports the organizational code of ethics?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
INDIVIDUAL AND ORGANIZATION BEHAVIOR (IOB)	Are you coached and/or mentored by hospital leadership?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6

Appendix B continued
Methodology for Operationalizing Variables, Measures, and Coding of Data

IOB2	Does hospital leadership openly communicate with you and solicit feedback?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
IOB3	Does hospital leadership motivate others through effective communication, reinforcement, recognition, and/or reward?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
IOB4	Do hospital leaders clearly define and articulate goals, tasks, purposes, and parameters?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
IOB5	Do hospital leaders select decision-making techniques and problem solving approaches appropriate to the situation?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
IOB6	Does hospital leadership develop an organizational climate in which groups can openly deliberate and report findings without fear of reprisal?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
IOB7	Do hospital leaders solicit and incorporate feedback, ideas, comments, and suggestions from others?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
IOB8	Do hospital leaders monitor individual and/or group progress, providing interim guidance and intervention as necessary?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
IOB9	Within a given year, how often are you counseled by management or supervisor?	NEVER=1, ONCE=2, TWICE=3, ≥THREE TIMES=4, DON'T KNOW=5

Appendix B continued
Methodology for Operationalizing Variables, Measures, and Coding of Data

IOB10	Do hospital leaders emphasize involvement, empowerment, and encourage continuous learning and reengineering efforts?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
IOB11	Do hospital leaders involve key stakeholders in critical processes?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
IOB12	Do hospital leaders make business decisions and solve problems based on results from quantitative and qualitative methods?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
IOB13	Does hospital leadership employ best business and practice guidelines to enhance organization performance?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
IOB14	What degree of trust do you have in hospital leadership to make appropriate change(s) in the employee work environment?	NONE=1, LOW DEGREE=2, MODERATE DEGREE=3, HIGH DEGREE=4, DON'T KNOW=5
SAFETY	Does the hospital have an effective patient safety and risk management program?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
SAFETY2	Does hospital leadership employ tools and techniques to aid in risk analysis and reduction?	NOT REALLY=1, SOMETIMES=2, OFTEN=3, MOSTLY=4, ALWAYS=5, DON'T KNOW=6
SAFETY3	Has hospital leadership implemented the National Patient Safety Goals and JCAHO Patient Safety Standards?	NOT REALLY=1, SOME=2, MOST=3, ALL=4, DON'T KNOW=5

Appendix C
Management and Employee Response Frequencies

Table 6
Comparison Between Management and Employee Response Frequencies

Demographics	Employees Frequency	%	Management Frequency	%
Gender				
Male	77	34.2	14	50
Female	148	65.8	14	50
Age				
17-20	1	.4	0	0
21-25	10	4.4	0	0
26-31	31	13.8	0	0
32-36	33	14.7	4	14.3
37-41	34	15.1	2	7.1
42-47	34	18.7	12	42.9
48-53	42	18.7	8	28.6
54>	32	14.2	2	7.1
Ethnicity				
Hispanic	30	13.3	3	10.7
African American	68	30.2	2	7.1
Caucasian	103	45.8	23	82.1
Asian/Pacific Islander	11	4.9	0	0
Native American	2	.9	0	0
Other	11	4.9	0	0
Pay Grade				
O1-O3	22	9.8	1	3.6
O4-O5	17	7.6	21	75.0
O6>	1	.4	6	21.4
E-1-E-4	9	4.0	0	0
E-5-E-6	9	4.0	0	0
E-7-E-8	8	3.6	0	0
E-9	1	1	0	0
CW3-CW4	1	.4	0	0
GS01-GS05	50	22.2	0	0
GS06-GS09	49	21.8	0	0
GS10-GS12	26	11.6	0	0
GS13>	2	.9	0	0
Wage Grade	5	2.2	0	0
Contract Civilian	25	11.1	0	0

Appendix C continued
Management and Employee Response Frequencies

Table 6 continued
Comparison Between Management and Employee Response Frequencies

Demographics	Employees Frequency	%	Management Frequency	%
Military Status				
Active Duty	62	27.6	26	92.9
Activated Guard/Reserve	4	1.8	2	7.1
Retired Military	24	10.7	0	0
Prior Service	32	14.2	0	0
N/A	103	45.8	0	0
Education Level				
High School Grad or Equivalent	16	7.1	0	0
Some College	70	31.1	0	0
Associates Degree	51	22.7	0	0
Bachelors Degree	38	16.9	1	3.6
Masters Degree or Higher	50	22.2	27	96.4
Length of Federal Service				
<1 Year	8	3.6	0	0
1-3 Years	29	12.9	0	0
4-6 Years	34	15.1	1	3.6
7-10 Years	30	13.3	1	3.6
11-15 Years	38	16.9	4	14.3
>15 Years	86	38.2	22	78.6
Length of Service at DACH				
<1 Year	29	12.9	7	25.0
1-3 Years	77	34.2	14	50.0
4-6 Years	37	16.4	5	17.9
7-10 Years	23	10.2	2	7.1
11-15 Years	24	10.7	0	0
>15 Years	35	15.6	0	0

Appendix C continued
Management and Employee Response Frequencies

Table 6 continued

Comparison Between Management and Employee Response Frequencies

Demographics	Employees		Management	
	Frequency	%	Frequency	%
Level of Work				
Senior Management	6	2.7	10	35.7
Middle Management	11	4.9	12	42.9
Supervisory	25	11.1	2	7.1
Professional	77	34.2	4	14.3
Paraprofessional	15	6.7	0	0
Administrator	11	4.9	0	0
Technical	34	15.1	0	0
Clerical	32	14.2	0	0
Labor	5	2.2	0	0
Other	9	4.0	0	0
Classification of Primary Function				
Physician	22	9.8	10	35.7
Non-Physician Provider	32	14.2	6	21.4
Administrator	33	14.7	9	32.1
Medical Technician or Assistant	44	19.6	0	0
Medical Therapist or Technologist	15	6.7	0	0
Other	79	35.1	3	10.7

Appendix C continued
Management and Employee Response Frequencies

Table 7
Employee Core Competency Response Frequencies

Strategic Planning					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	8	3.6	3.6	3.6
	Low	20	8.9	8.9	12.4
	Moderate	95	42.2	42.2	54.7
	High	49	21.8	21.8	76.4
	Don't Know	53	23.6	23.6	100.0
	Total	225	100.0	100.0	

Organization Design					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	34	15.1	15.1	15.1
	Minimally	35	15.6	15.6	30.7
	Moderately	94	41.8	41.8	72.4
	Highly	41	18.2	18.2	90.7
	Don't Know	21	9.3	9.3	100.0
	Total	225	100.0	100.0	

Decision Making					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	11	4.9	4.9	4.9
	Sometimes	58	25.8	25.8	30.7
	Often	35	15.6	15.6	46.2
	Mostly	77	34.2	34.2	80.4
	Always	16	7.1	7.1	87.6
	Don't Know	28	12.4	12.4	100.0
	Total	225	100.0	100.0	

Change and Innovation					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	26	11.6	11.6	11.6
	Minimally	51	22.7	22.7	34.2
	Moderately	73	32.4	32.4	66.7
	Highly	46	20.4	20.4	87.1
	Don't Know	25	11.1	11.1	98.2
	6.00	4	1.8	1.8	100.0
	Total	225	100.0	100.0	

Change and Innovation2					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	49	21.8	21.8	21.8
	Sometimes	56	24.9	24.9	46.7
	Often	36	16.0	16.0	62.7
	Mostly	41	18.2	18.2	80.9
	Always	34	15.1	15.1	96.0
	Don't Know	9	4.0	4.0	100.0
	Total	225	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 7 continued
Employee Core Competency Response Frequencies

Leadership

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	38	16.9	16.9	16.9
	Sometimes	68	30.2	30.2	47.1
	Often	32	14.2	14.2	61.3
	Mostly	60	26.7	26.7	88.0
	Always	11	4.9	4.9	92.9
	Don't Know	16	7.1	7.1	100.0
	Total	225	100.0	100.0	

Leadership2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Authoritative/Dictatorial	24	10.7	10.7	10.7
	Supportive	83	36.9	36.9	47.6
	Participative/Engaging	50	22.2	22.2	69.8
	Achievement/Goal Oriented	39	17.3	17.3	87.1
	Absence of Leadership	29	12.9	12.9	100.0
	Total	225	100.0	100.0	

Leadership3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	44	19.6	19.6	19.6
	Sometimes	52	23.1	23.1	42.7
	Often	20	8.9	8.9	51.6
	Mostly	84	37.3	37.3	88.9
	Always	20	8.9	8.9	97.8
	Don't Know	5	2.2	2.2	100.0
	Total	225	100.0	100.0	

Law and Policy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	25	11.1	11.1	11.1
	Sometimes	34	15.1	15.1	26.2
	Often	16	7.1	7.1	33.3
	Mostly	57	25.3	25.3	58.7
	Always	57	25.3	25.3	84.0
	Don't Know	36	16.0	16.0	100.0
	Total	225	100.0	100.0	

Law and Policy2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	4	1.8	1.8	1.8
	Sometimes	21	9.3	9.3	11.1
	Often	20	8.9	8.9	20.0
	Mostly	58	25.8	25.8	45.8
	Always	58	25.8	25.8	71.6
	Don't Know	64	28.4	28.4	100.0
	Total	225	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 7 continued
Employee Core Competency Response Frequencies

Law and policy3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	2	.9	.9	.9
	Sometimes	19	8.4	8.4	9.3
	Often	23	10.2	10.2	19.6
	Mostly	60	26.7	26.7	46.2
	Always	71	31.6	31.6	77.8
	Don't Know	50	22.2	22.2	100.0
	Total	225	100.0	100.0	

Resources Allocation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	66	29.3	29.3	29.3
	Sometimes	36	16.0	16.0	45.3
	Often	30	13.3	13.3	58.7
	Mostly	58	25.8	25.8	84.4
	Always	12	5.3	5.3	89.8
	Don't Know	23	10.2	10.2	100.0
	Total	225	100.0	100.0	

Resources Allocation2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	48	21.3	21.3	21.3
	Sometimes	55	24.4	24.4	45.8
	Often	40	17.8	17.8	63.6
	Mostly	44	19.6	19.6	83.1
	Always	29	12.9	12.9	96.0
	Don't Know	9	4.0	4.0	100.0
	Total	225	100.0	100.0	

Resources Allocation3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	57	25.3	25.3	25.3
	Sometimes	53	23.6	23.6	48.9
	Often	24	10.7	10.7	59.6
	Mostly	65	28.9	28.9	88.4
	Always	17	7.6	7.6	96.0
	Don't Know	9	4.0	4.0	100.0
	Total	225	100.0	100.0	

Resources Allocation4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	14	6.2	6.2	6.2
	Sometimes	37	16.4	16.4	22.7
	Often	22	9.8	9.8	32.4
	Mostly	52	23.1	23.1	55.6
	Always	33	14.7	14.7	70.2
	Don't Know	67	29.8	29.8	100.0
	Total	225	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 7 continued
Employee Core Competency Response Frequencies

Resources Allocation5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	7	3.1	3.1	3.1
	Sometimes	31	13.8	13.8	16.9
	Often	34	15.1	15.1	32.0
	Mostly	79	35.1	35.1	67.1
	Always	62	27.6	27.6	94.7
	Don't Know	12	5.3	5.3	100.0
	Total	225	100.0	100.0	

Resources Allocation6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Poor/Failing	9	4.0	4.0	4.0
	Marginal/Needs Moderate Improvement	59	26.2	26.2	30.2
	Adequate/Needs Minor Improvement	86	38.2	38.2	68.4
	Good/Fully Adequate Environment of Care	60	26.7	26.7	95.1
	Great/A Benchmark for Environment of Care	11	4.9	4.9	100.0
	Total	225	100.0	100.0	

Ethics

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	18	8.0	8.0	8.0
	Sometimes	42	18.7	18.7	26.7
	Often	21	9.3	9.3	36.0
	Mostly	74	32.9	32.9	68.9
	Always	55	24.4	24.4	93.3
	Don't Know	15	6.7	6.7	100.0
	Total	225	100.0	100.0	

Ethics2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	19	8.4	8.4	8.4
	Sometimes	29	12.9	12.9	21.3
	Often	24	10.7	10.7	32.0
	Mostly	77	34.2	34.2	66.2
	Always	58	25.8	25.8	92.0
	Don't Know	18	8.0	8.0	100.0
	Total	225	100.0	100.0	

Ethics3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	7	3.1	3.1	3.1
	Sometimes	12	5.3	5.3	8.4
	Often	16	7.1	7.1	15.6
	Mostly	52	23.1	23.1	38.7
	Always	79	35.1	35.1	73.8
	Don't Know	59	26.2	26.2	100.0
	Total	225	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 7 continued
Employee Core Competency Response Frequencies

		Ethics4			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	10	4.4	4.4	4.4
	Sometimes	20	8.9	8.9	13.3
	Often	30	13.3	13.3	26.7
	Mostly	78	34.7	34.7	61.3
	Always	59	26.2	26.2	87.6
	Don't Know	28	12.4	12.4	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	83	36.9	36.9	36.9
	Sometimes	60	26.7	26.7	63.6
	Often	13	5.8	5.8	69.3
	Mostly	46	20.4	20.4	89.8
	Always	14	6.2	6.2	96.0
	Don't Know	9	4.0	4.0	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	66	29.3	29.3	29.3
	Sometimes	62	27.6	27.6	56.9
	Often	30	13.3	13.3	70.2
	Mostly	45	20.0	20.0	90.2
	Always	18	8.0	8.0	98.2
	Don't Know	4	1.8	1.8	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	51	22.7	22.7	22.7
	Sometimes	76	33.8	33.8	56.4
	Often	22	9.8	9.8	66.2
	Mostly	50	22.2	22.2	88.4
	Always	12	5.3	5.3	93.8
	Don't Know	14	6.2	6.2	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	29	12.9	12.9	12.9
	Sometimes	58	25.8	25.8	38.7
	Often	40	17.8	17.8	56.4
	Mostly	60	26.7	26.7	83.1
	Always	27	12.0	12.0	95.1
	Don't Know	11	4.9	4.9	100.0
	Total	225	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 7 continued
Employee Core Competency Response Frequencies

Individual and Organization Behavior5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	25	11.1	11.1	11.1
	Sometimes	53	23.6	23.6	34.7
	Often	36	16.0	16.0	50.7
	Mostly	64	28.4	28.4	79.1
	Always	14	6.2	6.2	85.3
	Don't Know	33	14.7	14.7	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	38	16.9	16.9	16.9
	Sometimes	44	19.6	19.6	36.4
	Often	26	11.6	11.6	48.0
	Mostly	60	26.7	26.7	74.7
	Always	21	9.3	9.3	84.0
	Don't Know	36	16.0	16.0	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	31	13.8	13.8	13.8
	Sometimes	60	26.7	26.7	40.4
	Often	23	10.2	10.2	50.7
	Mostly	56	24.9	24.9	75.6
	Always	22	9.8	9.8	85.3
	Don't Know	33	14.7	14.7	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior8

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	28	12.4	12.4	12.4
	Sometimes	48	21.3	21.3	33.8
	Often	27	12.0	12.0	45.8
	Mostly	41	18.2	18.2	64.0
	Always	22	9.8	9.8	73.8
	Don't Know	59	26.2	26.2	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior9

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	30	13.3	13.3	13.3
	Once	67	29.8	29.8	43.1
	Twice	74	32.9	32.9	76.0
	>=Three Times	43	19.1	19.1	95.1
	Don't Know	10	4.4	4.4	99.6
	6.00	1	.4	.4	100.0
	Total	225	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 7 continued
Employee Core Competency Response Frequencies

Individual and Organization Behavior10

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	48	21.3	21.3	21.3
	Sometimes	49	21.8	21.8	43.1
	Often	32	14.2	14.2	57.3
	Mostly	49	21.8	21.8	79.1
	Always	25	11.1	11.1	90.2
	Don't Know	22	9.8	9.8	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior11

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	26	11.6	11.6	11.6
	Sometimes	34	15.1	15.1	26.7
	Often	27	12.0	12.0	38.7
	Mostly	36	16.0	16.0	54.7
	Always	17	7.6	7.6	62.2
	Don't Know	85	37.8	37.8	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior12

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	22	9.8	9.8	9.8
	Sometimes	34	15.1	15.1	24.9
	Often	23	10.2	10.2	35.1
	Mostly	39	17.3	17.3	52.4
	Always	17	7.6	7.6	60.0
	Don't Know	90	40.0	40.0	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior13

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	25	11.1	11.1	11.1
	Sometimes	48	21.3	21.3	32.4
	Often	26	11.6	11.6	44.0
	Mostly	48	21.3	21.3	65.3
	Always	17	7.6	7.6	72.9
	Don't Know	61	27.1	27.1	100.0
	Total	225	100.0	100.0	

Safety

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	6	2.7	2.7	2.7
	Sometimes	34	15.1	15.1	17.8
	Often	25	11.1	11.1	28.9
	Mostly	63	28.0	28.0	56.9
	Always	41	18.2	18.2	75.1
	Don't Know	56	24.9	24.9	100.0
	Total	225	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 7 continued
Employee Core Competency Response Frequencies

Safety2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	11	4.9	4.9	4.9
	Often	65	28.9	28.9	33.8
	Mostly	124	55.1	55.1	88.9
	Always	25	11.1	11.1	100.0
	Total	225	100.0	100.0	

Safety3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	24	10.7	10.7	10.7
	Some	54	24.0	24.0	34.7
	Most	93	41.3	41.3	76.0
	All	42	18.7	18.7	94.7
	Don't Know	12	5.3	5.3	100.0
	Total	225	100.0	100.0	

Individual and Organization Behavior14

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	9	4.0	4.0	4.0
	Low Degree	17	7.6	7.6	11.6
	Moderate Degree	26	11.6	11.6	23.1
	High Degree	76	33.8	33.8	56.9
	Don't Know	67	29.8	29.8	86.7
	6.00	30	13.3	13.3	100.0
	Total	225	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 8

Management Core Competency Response Frequencies

Strategic Planning

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low Degree	4	14.3	14.3	14.3
	Moderate Degree	12	42.9	42.9	57.1
	High Degree	12	42.9	42.9	100.0
	Total	28	100.0	100.0	

Organization Design

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	4	14.3	14.3	14.3
	Minimally	4	14.3	14.3	28.6
	Moderately	14	50.0	50.0	78.6
	Highly	5	17.9	17.9	96.4
	Don't Know	1	3.6	3.6	100.0
	Total	28	100.0	100.0	

Decision Making

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	2	7.1	7.1	7.1
	Often	6	21.4	21.4	28.6
	Mostly	5	17.9	17.9	46.4
	Always	15	53.6	53.6	100.0
	Total	28	100.0	100.0	

Change and Innovation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Minimally	7	25.0	25.0	25.0
	Moderately	15	53.6	53.6	78.6
	Highly	3	10.7	10.7	89.3
	Don't Know	3	10.7	10.7	100.0
	Total	28	100.0	100.0	

Change and Innovation2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	3	10.7	10.7	10.7
	Often	5	17.9	17.9	28.6
	Mostly	2	7.1	7.1	35.7
	Always	18	64.3	64.3	100.0
	Total	28	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 8 continued
Management Core Competency Response Frequencies

Leadership

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	2	7.1	7.1	7.1
	Often	6	21.4	21.4	28.6
	Mostly	11	39.3	39.3	67.9
	Always	9	32.1	32.1	100.0
	Total	28	100.0	100.0	

Leadership2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Authoritative/Dictatorial	1	3.6	3.6	3.6
	Supportive	7	25.0	25.0	28.6
	Participative/Engaging	13	46.4	46.4	75.0
	Achievement/Goal Oriented	7	25.0	25.0	100.0
	Total	28	100.0	100.0	

Leadership3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	2	7.1	7.1	7.1
	Often	2	7.1	7.1	14.3
	Mostly	13	46.4	46.4	60.7
	Always	11	39.3	39.3	100.0
	Total	28	100.0	100.0	

Law and Policy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Often	1	3.6	3.6	3.6
	Mostly	4	14.3	14.3	17.9
	Always	22	78.6	78.6	96.4
	Don't Know	1	3.6	3.6	100.0
	Total	28	100.0	100.0	

Law and Policy2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	1	3.6	3.6	3.6
	Sometimes	2	7.1	7.1	10.7
	Mostly	5	17.9	17.9	28.6
	Always	18	64.3	64.3	92.9
	Don't Know	2	7.1	7.1	100.0
	Total	28	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 8 continued

Management Core Competency Response Frequencies

Law and policy3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	1	3.6	3.6	3.6
	Often	1	3.6	3.6	7.1
	Mostly	10	35.7	35.7	42.9
	Always	16	57.1	57.1	100.0
	Total	28	100.0	100.0	

Resources Allocation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	1	3.6	3.6	3.6
	Often	2	7.1	7.1	10.7
	Mostly	4	14.3	14.3	25.0
	Always	21	75.0	75.0	100.0
	Total	28	100.0	100.0	

Resources Allocation2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	3	10.7	10.7	10.7
	Often	4	14.3	14.3	25.0
	Mostly	8	28.6	28.6	53.6
	Always	13	46.4	46.4	100.0
	Total	28	100.0	100.0	

Resources Allocation3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	2	7.1	7.1	7.1
	Often	3	10.7	10.7	17.9
	Mostly	10	35.7	35.7	53.6
	Always	13	46.4	46.4	100.0
	Total	28	100.0	100.0	

Resources Allocation4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Often	2	7.1	7.1	7.1
	Mostly	7	25.0	25.0	32.1
	Always	17	60.7	60.7	92.9
	Don't Know	2	7.1	7.1	100.0
	Total	28	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 8 continued
Management Core Competency Response Frequencies

Resources Allocation5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	2	7.1	7.1	7.1
	Often	4	14.3	14.3	21.4
	Mostly	12	42.9	42.9	64.3
	Always	10	35.7	35.7	100.0
	Total	28	100.0	100.0	

Resources Allocation6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Poor/Failing	1	3.6	3.6	3.6
	Marginal/Needs				
	Moderate Improvement	11	39.3	39.3	42.9
	Adequate/Needs Minor Improvement	12	42.9	42.9	85.7
	Good/Fully Adequate Environment of Care	4	14.3	14.3	100.0
	Total	28	100.0	100.0	

Ethics

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Often	1	3.6	3.6	3.6
	Mostly	8	28.6	28.6	32.1
	Always	19	67.9	67.9	100.0
	Total	28	100.0	100.0	

Ethics2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Mostly	4	14.3	14.3	14.3
	Always	24	85.7	85.7	100.0
	Total	28	100.0	100.0	

Ethics3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	1	3.6	3.6	3.6
	Often	2	7.1	7.1	10.7
	Mostly	1	3.6	3.6	14.3
	Always	24	85.7	85.7	100.0
	Total	28	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 8 continued
Management Core Competency Response Frequencies

Ethics4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Often	1	3.6	3.6	3.6
	Mostly	4	14.3	14.3	17.9
	Always	23	82.1	82.1	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	3	10.7	10.7	10.7
	Often	5	17.9	17.9	28.6
	Mostly	6	21.4	21.4	50.0
	Always	14	50.0	50.0	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Often	7	25.0	25.0	25.0
	Mostly	7	25.0	25.0	50.0
	Always	14	50.0	50.0	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	3	10.7	10.7	10.7
	Often	5	17.9	17.9	28.6
	Mostly	10	35.7	35.7	64.3
	Always	10	35.7	35.7	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	2	7.1	7.1	7.1
	Often	3	10.7	10.7	17.9
	Mostly	14	50.0	50.0	67.9
	Always	9	32.1	32.1	100.0
	Total	28	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 8 continued
Management Core Competency Response Frequencies

Individual and Organization Behavior5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	1	3.6	3.6	3.6
	Often	3	10.7	10.7	14.3
	Mostly	16	57.1	57.1	71.4
	Always	7	25.0	25.0	96.4
	Don't Know	1	3.6	3.6	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	2	7.1	7.1	7.1
	Often	1	3.6	3.6	10.7
	Mostly	10	35.7	35.7	46.4
	Always	15	53.6	53.6	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Often	4	14.3	14.3	14.3
	Mostly	8	28.6	28.6	42.9
	Always	16	57.1	57.1	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior8

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	1	3.6	3.6	3.6
	Sometimes	1	3.6	3.6	7.1
	Often	3	10.7	10.7	17.9
	Mostly	15	53.6	53.6	71.4
	Always	8	28.6	28.6	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior9

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Once	1	3.6	3.6	3.6
	Twice	9	32.1	32.1	35.7
	>=Three Times	15	53.6	53.6	89.3
	Don't Know	3	10.7	10.7	100.0
	Total	28	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 8 continued
Management Core Competency Response Frequencies

Individual and Organization Behavior10

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	1	3.6	3.6	3.6
	Sometimes	2	7.1	7.1	10.7
	Often	3	10.7	10.7	21.4
	Mostly	10	35.7	35.7	57.1
	Always	12	42.9	42.9	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior11

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	1	3.6	3.6	3.6
	Often	4	14.3	14.3	17.9
	Mostly	8	28.6	28.6	46.4
	Always	15	53.6	53.6	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior12

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	2	7.1	7.1	7.1
	Often	6	21.4	21.4	28.6
	Mostly	14	50.0	50.0	78.6
	Always	5	17.9	17.9	96.4
	Don't Know	1	3.6	3.6	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior13

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	5	17.9	17.9	17.9
	Often	2	7.1	7.1	25.0
	Mostly	11	39.3	39.3	64.3
	Always	8	28.6	28.6	92.9
	Don't Know	2	7.1	7.1	100.0
	Total	28	100.0	100.0	

Safety

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	2	7.1	7.1	7.1
	Sometimes	6	21.4	21.4	28.6
	Often	4	14.3	14.3	42.9
	Mostly	8	28.6	28.6	71.4
	Always	7	25.0	25.0	96.4
	Don't Know	1	3.6	3.6	100.0
	Total	28	100.0	100.0	

Appendix C continued
Management and Employee Response Frequencies

Table 8 continued
Management Core Competency Response Frequencies

Safety2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Really	1	3.6	3.6	3.6
	Sometimes	2	7.1	7.1	10.7
	Often	11	39.3	39.3	50.0
	Mostly	14	50.0	50.0	100.0
	Total	28	100.0	100.0	

Safety3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Somewhat	4	14.3	14.3	14.3
	Considerably	7	25.0	25.0	39.3
	Very Much	14	50.0	50.0	89.3
	Don't Know	3	10.7	10.7	100.0
	Total	28	100.0	100.0	

Individual and Organization Behavior14

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Moderate Degree	2	7.1	7.1	7.1
	High Degree	8	28.6	28.6	35.7
	Don't Know	18	64.3	64.3	100.0
	Total	28	100.0	100.0	

Appendix D
Analysis of Variance Significant Results

Table 9

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Gender					
Highest Education Level					
Between Groups	5.143	1	5.143	3.04	.076
Within Groups	39.286	26	1.511		
Strategic Planning					
Between Groups	9.143	1	9.143	8.712	.007
Within Groups	27.286	26	1.049		
Leadership					
Between Groups	7.000	1	7.000	3.406	.076
Within Groups	53.429	26	2.055		
Ethics ⁴					
Between Groups	5.143	1	5.143	4.087	.054
Within Groups	32.714	26	1.258		
Ind. & Org. Behavior ⁴					
Between Groups	5.143	1	5.143	3.586	.069
Within Groups	37.286	26	1.434		
Age					
Ind. & Org. Behavior ⁹					
Between Groups	14.940	4	3.735	4.059	.012
Within Groups	21.167	23	.920		
Safety ³					
Between Groups	11.464	4	2.866	8.789	.000
Within Groups	7.5000	23			

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Ethnicity					
Organizational Design					
Between Groups	10.700	2	5.350	5.149	.013
Within Groups	25.978	25	1.039		
Decision Making					
Between Groups	15.031	2	7.516	4.492	.022
Within Groups	41.826	25	1.673		
Ind. & Org. Behavior ³					
Between Groups	22.559	2	11.280	6.016	.007
Within Groups	46.870	25	1.875		
Ind. & Org. Behavior ⁶					
Between Groups	23.672	2	11.836	3.272	.055
Within Groups	90.435	25	3.617		
Pay Grade					
Length of Federal Service					
Between Groups	20.012	2	10.006	3.863	.034
Within Groups	64.667	25	2.587		
Ethics ³					
Between Groups	13.560	2	6.780	4.094	.029
Within Groups	41.405	25	1.656		
Safety ²					
Between groups	1.929	2	.964	3.214	.057
Within Groups	7.500	25	.300		

* $P < .05$

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Military Status					
Ind. & Org. Behavior ⁹					
Between Groups	6.069	1	6.069	5.253	.030
Within Groups	30.038	26	1.155		
Highest Education Level					
Ind. & Org. Behavior					
Between Groups	14.307	1	14.307	7.846	.009
Within Groups	41.407	26	1.823		
Ind. & Org. Behavior ²					
Between Groups	14.307	1	14.307	8.983	.006
Within Groups	41.407	26	1.593		
Ind. & Org. Behavior ³					
Between Groups	10.243	1	10.243	4.500	.044
Within Groups	59.185	26	2.276		
Length of Federal Service					
Resource Allocation ⁶					
Between Groups	6.403	3	2.134	2.893	.056
Within Groups	17.705	24	.738		
Level of Work					
Ind. & Org. Behavior ¹⁰					
Between Groups	26.112	3	8.704	3.339	.036
Within Groups	62.567	24	2.607		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Length of Service at DACH					
Ind. & Org. Behavior ⁵					
Between Groups	36.000	3	12.000	6.720	.002
Within Groups	42.857	24	1.786		
Classification of Primary Function					
Safety					
Between Groups	12.056	3	4.019	3.150	.043
Within Groups	30.622	24	1.276		
Safety ²					
Between Groups	2.973	3	.991	3.684	.026
Within Groups	6.456	24	.269		
Organizational Design					
Level of Work					
Between Groups	36.836	4	9.209	2.701	.056
Within Groups	78.414	23	3.409		
Leadership					
Between Groups	29.979	4	7.495	5.661	.003
Within Groups	30.450	23	1.324		
Safety ³					
Between Groups	6.036	4	1.509	2.684	.057
Within Groups	12.929	23	.562		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Decision Making					
Level of Work					
Between Groups	54.983	3	18.328	7.299	.001
Within Groups	60.267	24	2.511		
Ethics2					
Between Groups	8.862	3	2.954	2.669	.070
Within Groups	26.567	24	1.107		
Ethics3					
Between Groups	21.998	3	7.333	5.338	.006
Within Groups	32.967	24	1.374		
Ind. & Org. Behavior6					
Between Groups	51.974	3	17.325	6.692	.002
Within Groups	62.133	24	2.589		
Ind. & Org. Behavior7					
Between Groups	22.162	3	7.387	3.043	.048
Within Groups	58.267	24	2.428		
Change and Innovation					
Leadership2					
Between Groups	9.886	3	3.295	2.626	.074
Within Groups	30.114	24	1.255		
Safety2					
Between Groups	2.838	3	.946	3.445	.033
Within Groups	6.590	24	.275		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Change and Innovation ²					
Age					
Between Groups	16.598	3	5.533	3.134	.044
Within Groups	42.367	24	1.765		
Length of Federal Service					
Between Groups	23.512	3	7.837	3.075	.047
Within Groups	61.167	24	2.549		
Length of Service at DACH					
Between Groups	17.089	3	5.696	2.685	.069
Within Groups	50.911	24	2.121		
Change and Innovation ²					
Between Groups	18.853	3	6.284	2.595	.076
Within Groups	58.111	24	2.421		
Ind. & Org. Behavior ⁶					
Between Groups	39.029	3	13.010	4.159	.017
Within Groups	75.078	24	3.128		
Ind. & Org. Behavior ⁷					
Between Groups	25.517	3	8.506	3.718	.025
Within Groups	54.911	24	2.288		
Ind. & Org. Behavior ⁸					
Between Groups	26.689	3	8.896	3.220	.041
Within Groups	66.311	24	2.763		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Change and Innovation ²					
Ind. & Org. Behavior ¹⁰					
Between Groups	21.867	3	7.289	2.618	.074
Within Groups	66.811	24	2.784		
Leadership					
Leadership ²					
Between Groups	13.621	3	4.540	4.131	.017
Within Groups	26.379	24	1.099		
Ethics ³					
Between Groups	15.030	3	5.010	3.011	.050
Within Groups	39.934	24	1.664		
Ind. & Org. Behavior ⁶					
Between Groups	33.476	3	11.159	3.321	.037
Within Groups	80.631	24	3.360		
Leadership ²					
Strategic Planning					
Between Groups	9.571	3	3.190	2.851	.059
Within Groups	26.857	24	1.119		
Resource Allocation ⁶					
Between Groups	6.591	3	2.197	3.010	.050
Within Groups	17.516	24	.730		

*P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig
Leadership2					
Ethics3					
Between Groups	18.327	3	6.109	4.002	.019
Within Groups	36.637	24	1.527		
Leadership3					
Classification of Primary Function					
Between Groups	30.055	3	10.018	2.832	.060
Within Groups	84.909	24	3.538		
Leadership2					
Between Groups	10.587	3	3.529	2.880	.057
Within Groups	29.413	24	1.226		
Resource Allocation4					
Between Groups	16.792	3	5.597	2.892	.056
Within Groups	46.458	24	1.936		
Ethics3					
Between Groups	18.157	3	6.052	3.946	.020
Within Groups	36.808	24	1.534		
Law and Policy					
Classification of Primary Function					
Between Groups	35.192	3	11.731	3.529	.030
Within Groups	79.775	24	3.324		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Law and Policy2					
Organizational Design					
Between Groups	11.879	4	2.970	2.754	.052
Within Groups	24.800	23	1.078		
Ethics					
Between Groups	14.451	4	3.613	2.682	.057
Within Groups	30.979	23	1.347		
Ethics3					
Between Groups	27.487	4	6.872	5.752	.002
Within Groups	27.478	23	1.195		
Ind. & Org. Behavior3					
Between Groups	23.429	4	5.857	2.929	.043
Within Groups	46.000	23	2.000		
Ind. & Org. Behavior10					
Between Groups	30.534	4	7.634	3.020	.039
Within Groups	58.144	23	2.528		
Safety3					
Between Groups	6.020	4	1.505	2.674	.058
Within Groups	12.944	23	.563		
Law and Policy3					
Safety3					
Between Groups	5.927	3	1.976	3.637	.027
Within Groups	13.038	24	.543		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Law and Policy ³					
Resource Allocation ⁴					
Between Groups	15.500	3	5.167	2.597	.076
Within Groups	47.750	24	1.990		
Ethics ³					
Between Groups	14.314	3	4.771	2.817	.061
Within Groups	40.656	24	1.694		
Ind. & Org. Behavior ³					
Between Groups	17.279	3	5.760	2.651	.072
Within Groups	52.150	24	2.173		
Resource Allocation					
Level of Work					
Between Groups	35.357	3	11.786	3.540	.030
Within Groups	79.893	24	3.329		
Law and Policy					
Between Groups	21.726	3	7.242	3.343	.036
Within Groups	51.988	24	2.166		
Law and Policy ³					
Between Groups	14.429	3	4.810	3.544	.030
Within Groups	32.571	24	1.357		
Ind. & Org. Behavior ⁷					
Between Groups	21.393	3	7.131	2.899	.056
Within Groups	59.036	24	2.460		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Resource Allocation					
Ind. & Org. Behavior ¹⁰					
Between Groups	42.976	3	14.325	7.523	.001
Within Groups	45.702	24	1.904		
Resource Allocation ⁴					
Between Groups	24.000	3	8.000	4.892	.009
Within Groups	39.250	24	1.635		
Resource Allocation ²					
Ethics					
Between Groups	14.368	3	4.789	3.701	.025
Within Groups	31.061	24	1.294		
Ethics ³					
Between Groups	35.740	3	11.913	14.873	.000
Within Groups	19.224	24	.801		
Ind. & Org. Behavior ⁹					
Between Groups	12.046	3	4.015	4.005	.019
Within groups	24.061	24	1.003		
Ind. & Org. Behavior ¹⁴					
Between Groups	15.500	3	5.167	3.245	.040
Within Groups	38.215	24	1.592		
Resource Allocation ³					
Law and Policy					
Between Groups	18.278	3	6.093	2.638	.073
Within Groups	55.436	24	2.310		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Resource Allocation3					
Ind. & Org. Behavior10					
Between Groups	23.320	3	7.773	2.854	.058
Within Groups	65.359	24	2.723		
Resource Allocation4					
Organizational Design					
Between Groups	9.309	3	3.103	2.721	.067
Within Groups	27.370	24	1.140		
Resource Allocation4					
Between Groups	18.011	3	6.004	3.185	.042
Within Groups	45.239	24	1.885		
Resource Allocation5					
Resource Allocation2					
Between Groups	15.662	3	5.221	3.385	.035
Within Groups	37.017	24	1.542		
Resource Allocation4					
Between Groups	18.233	3	6.078	3.240	.040
Within Groups	45.017	24	1.876		
Ind. & Org. Behavior9					
Between Groups	12.340	3	4.113	4.154	.017
Within Groups	23.767	24	.990		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Resource Allocation ⁶					
Length of Federal Service					
Between Groups	24.285	3	8.095	3.217	.041
Within Groups	60.394	24	2.516		
Change and Innovation ²					
Between Groups	19.116	3	6.372	2.644	.072
Within Groups	57.848	24	2.410		
Resource Allocation ²					
Between Groups	14.126	3	4.709	2.931	.054
Within Groups	38.553	24	1.606		
Ethics ⁴					
Between Groups	11.531	3	3.844	3.504	.031
Within Groups	26.326	24	1.097		
Ind. & Org. Behavior					
Between Groups	21.009	3	7.003	2.905	.055
Within Groups	57.848	24	2.410		
Safety ³					
Between Groups	5.116	3	1.705	2.955	.053
Within Groups	13.848	24	.577		
Ethics ²					
Gender					
Between Groups	.482	1	.482	3.458	.074
Within Groups	3.625	26	.139		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Ethics2					
Change and Innovation2					
Between Groups	10.006	1	10.006	3.885	.059
Within Groups	66.958	26	2.575		
Ind. & Org. Behavior6					
Between Groups	15.482	1	15.482	4.081	.054
Within Groups	98.625	26	3.793		
Ethics3					
Ethics					
Between Groups	12.470	3	4.157	3.027	.049
Within Groups	32.958	24	1.373		
Ethics4					
Change and Innovation2					
Between Groups	19.747	2	9.873	4.314	.025
Within Groups	57.217	25	2.289		
Leadership					
Between Groups	13.820	2	6.910	3.706	.039
Within Groups	46.609	25	1.864		
Individual and Organizational Behavior					
Classification of Primary Function					
Between Groups	36.050	3	12.017	3.655	.027
Within Groups	79.914	24	3.288		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Individual and Organizational Behavior					
Resource Allocation ⁴					
Between Groups	23.060	3	7.687	4.590	.011
Within Groups	40.190	24	1.675		
Ethics ³					
Between Groups	18.550	3	6.183	4.075	.018
Within Groups	36.414	24	1.517		
Ind. & Org. Behavior ⁶					
Between Groups	40.545	3	13.515	4.409	.013
Within Groups	73.562	24	3.065		
Ind. & Org. Behavior ⁷					
Between Groups	26.295	3	8.765	3.886	.021
Within Groups	73.562	24	2.256		
Individual and Organizational Behavior ²					
Ethnicity					
Between Groups	8.679	2	4.339	3.390	.050
Within Groups	32.000	25	1.280		
Ethics ⁴					
Between Groups	8.429	2	4.214	3.580	.043
Within Groups	29.429	25	1.177		
Ind. & Org. Behavior ³					
Between Groups	16.214	2	8.107	3.809	.036
Within Groups	53.214	25	2.129		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Individual and Organizational Behavior ²					
Ind. & Org. Behavior ⁴					
Between Groups	8.429	2	4.214	3.099	.065
Within Groups	34.000	25	1.360		
Ind. & Org. Behavior ⁶					
Between Groups	24.321	2	12.161	3.386	.050
Within Groups	89.786	25	3.591		
Ind. & Org. Behavior ⁷					
Between Groups	19.857	2	9.929	4.098	.029
Within Groups	60.571	25	2.423		
Individual and Organizational Behavior ³					
Classification of Primary Function					
Between Groups	30.598	3	10.199	2.901	.056
Within Groups	84.367	24	3.515		
Resource Allocation ⁴					
Between Groups	24.850	3	8.283	5.177	.007
Within Groups	38.400	24	1.600		
Ethics ³					
Between Groups	15.898	3	5.299	3.255	.039
Within Groups	39.067	24	1.628		
Ind. & Org. Behavior ⁶					
Between Groups	43.907	3	14.636	5.004	.008
Within Groups	70.200	24	2.925		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Individual and Organizational Behavior3					
Ind. & Org. Behavior7					
Between Groups	31.029	3	10.343	5.025	.008
Within Groups	49.400	24	2.058		
Ind. & Org. Behavior10					
Between Groups	30.579	3	10.193	4.210	.016
Within Groups	58.100	24	2.421		
Individual and Organizational Behavior4					
Resource Allocation4					
Between Groups	24.266	3	8.089	4.980	.008
Within Groups	38.984	24	1.624		
Individual and Organizational Behavior5					
Resource Allocation4					
Between Groups	23.146	4	5.786	3.319	.028
Within Groups	40.104	23	1.744		
Ind. & Org. Behavior6					
Between Groups	43.500	4	10.875	3.542	.022
Within Groups	70.607	23	3.070		
Ind. & Org. Behavior7					
Between Groups	32.777	4	8.194	3.955	.014
Within Groups	47.652	23	2.072		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Individual and Organizational Behavior6					
Military Status					
Between Groups	16.295	3	5.432	2.766	.064
Within Groups	47.133	24	1.964		
Classification of Primary Function					
Between Groups	36.964	3	12.321	3.791	.023
Within Groups	78.000	24	3.250		
Organizational Design					
Between Groups	12.045	3	4.015	3.912	.021
Within Groups	24.633	24	1.026		
Leadership2					
Between Groups	9.867	3	3.289	2.619	.074
Within Groups	30.133	24	1.256		
Ind. & Org. Behavior7					
Between Groups	21.895	3	7.298	2.993	.051
Within Groups	58.533	24	2.439		
Individual and Organizational Behavior7					
Ind. & Org. Behavior					
Between Groups	16.027	2	8.013	4.385	.023
Within Groups	45.688	25	1.828		
Ind. & Org. Behavior2					
Between Groups	16.027	2	8.013	5.048	.014
Within Groups	39.688	25	1.588		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Individual and Organizational Behavior7					
Ind. & Org. Behavior5					
Between Groups	19.045	2	9.322	3.980	.032
Within Groups	59.813	25	2.393		
Ind. & Org. Behavior6					
Between Groups	27.670	2	13.835	4.001	.031
Within Groups	86.438	25	3.458		
Ind. & Org. Behavior7					
Between Groups	26.679	2	13.339	6.204	.006
Within Groups	53.750	25	2.150		
Safety					
Between Groups	10.679	2	5.339	4.171	.027
Within Groups	32.000	25	1.280		
Individual and Organizational Behavior8					
Length of Federal Service					
Between Groups	30.404	4	7.601	3.221	.031
Within Groups	54.275	23	2.360		
Ind. & Org. Behavior					
Between Groups	19.714	4	4.929	2.699	.056
Within Groups	42.000	23	1.826		
Ind. & Org. Behavior6					
Between Groups	36.499	4	9.125	2.704	.056
Within Groups	77.608	23	3.374		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Individual and Organizational Behavior8					
Ind. & Org. Behavior7					
Between Groups	34.620	4	8.655	4.346	.009
Within Groups	45.808	23	1.992		
Individual and Organizational Behavior9					
Resource Allocation4					
Between Groups	15.517	3	5.172	2.601	.075
Within Groups	47.733	24	1.984		
Ethics2					
Between Groups	9.473	3	3.158	2.920	.055
Within Groups	25.956	24	1.081		
Ind. & Org. Behavior5					
Between Groups	19.924	3	6.641	2.705	.068
Within Groups	58.933	24	2.456		
Ind. & Org. Behavior6					
Between Groups	45.218	3	15.073	5.251	.006
Within Groups	68.889	24	2.870		
Individual and Organizational Behavior10					
Organizational Design					
Between Groups	12.862	4	3.215	3.105	.035
Within Groups	23.817	23	1.036		
Law and Policy					
Between Groups	30.948	4	7.737	4.161	.011
Within Groups	42.767	23	1.859		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Individual and Organizational Behavior10					
Resource Allocation4					
Between Groups	29.483	4	7.371	5.021	.005
Within Groups	33.767	23	1.859		
Ethics3					
Between Groups	27.198	4	6.799	5.632	.003
Within Groups	27.767	23	1.468		
Ind. & Org. Behavior6					
Between Groups	43.457	4	10.864	3.537	.022
Within Groups	70.650	23	3.072		
Individual and Organizational Behavior11					
Length of Federal Service					
Between Groups	21.804	3	7.268	2.774	.063
Within Groups	62.875	24	2.620		
Length of Service at DACH					
Between Groups	20.642	3	6.881	3.487	.031
Within Groups	47.358	24	1.973		
Strategic Planning					
Between Groups	11.070	3	3.690	3.492	.031
Within Groups	25.358	24	1.057		
Ind. & Org. Behavior5					
Between Groups	28.249	3	9.416	4.465	.013
Within Groups	50.608	24	2.109		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Individual and Organizational Behavior11					
Ind. & Org. Behavior6					
Between Groups	33.174	3	11.058	3.279	.038
Within Groups	80.933	24	3.372		
Ind. & Org. Behavior13					
Between Groups	19.749	3	6.583	2.618	.074
Within Groups	60.358	24	2.515		
Individual and Organizational Behavior12					
Resource Allocation4					
Between Groups	22.188	4	5.547	3.107	.035
Within Groups	41.062	23	1.785		
Safety					
Law and Policy3					
Between Groups	20.060	5	4.012	3.276	.023
Within Groups	26.940	22	1.225		
Ethics					
Between Groups	20.613	5	4.123	3.655	.015
Within Groups	24.815	22	1.128		
Ethics2					
Between Groups	12.738	5	2.548	2.470	.064
Within Groups	22.690	22	1.031		
Ind. & Org. Behavior14					
Between groups	20.542	5	4.108	2.725	.046
Within Groups	33.173	22	1.508		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Safety2					
Classification of Primary Function					
Between Groups	31.536	3	10.512	3.024	.049
Within Groups	83.429	24	3.476		
Leadership					
Between Groups	15.305	3	5.102	2.713	.067
Within Groups	45.123	24	1.880		
Safety3					
Between Groups	6.114	3	2.038	3.806	.023
Within Groups	12.851	24	.535		
Ind. & Org. Behavior14					
Between Groups	21.448	3	7.149	5.318	.006
Within Groups	32.266	24	1.344		
Safety3					
Leadership3					
Between Groups	14.357	3	4.786	3.473	.032
Within Groups	33.071	24	1.378		
Ethics3					
Between Groups	13.583	3	4.528	2.626	.074
Within Groups	41.381	24	1.724		
Ind. & Org. Behavior7					
Between Groups	20.500	3	6.833	2.737	.066
Within Groups	59.929	24	2.497		

* P < .05

Appendix D continued
Analysis of Variance Significant Results

Table 9 continued

Analysis of Variance Significant Results With Repeated Measures: Independent Management Response Affect on Employee Beliefs of Management Behavior

Management Affect Employee Beliefs	Sum of Squares	df	Mean Square	F*	sig.
Safety3					
Ind. & Org. Behavior9					
Between Groups	9.762	3	3.254	2.964	.052
Within Groups	26.345	24	1.098		
Individual and Organizational Behavior14					
Ind. & Org. Behavior13					
Between Groups	22.996	2	11.498	5.033	.015
Within Groups	57.111	25	2.284		

* P < .05

Appendix E
Management Behavior Assessment Cover Letter

Department of the Army
Headquarters, U.S. Army Medical Department Activity
36000 Darnall Loop
Fort Hood, Texas 76544-4752

Dear Colleague,

I am conducting a research study of the behavioral attributes displayed by hospital management, and you were selected based on a stratified random sampling taken from the entire population of hospital staff members. Participation is voluntary, but your responses are important to ensure greater validity of group data. In order to encourage respondent participation, all responses are held in the strictest of confidentiality.

Please complete the enclosed questionnaire and return it in the distribution envelope provided. Thank you for your participation and continued commitment to Darnall Army Community Hospital. Direct all questions to the undersigned at 288-8008 or by email at Steven.Shipley@cen.amedd.army.mil.

"One Team"

Sincerely,

Steven E. Shipley, Jr.
MAJ, MS
Health Care Administrative Resident

Appendix F
Hospital Staff View of Management Behavior Survey

The purpose of this questionnaire design is to document employee opinions about Management Behavior at Darnall Army Community Hospital (DACH). There are no right or wrong answers, simply answer all questions honestly. Please read each question carefully and check only one response per question. This questionnaire is completely anonymous. Your answers are confidential and all information gained in this study will only be presented as group data. Completion of this survey is voluntary and choosing not to complete the survey will not reflect poorly upon you in anyway. **Check only one response per question. Remember: Do not sign your name to the survey.**

1. What is your gender?
 - ☐ Male
 - ☐ Female

2. What is your age range?
 - ☐ 17-20
 - ☐ 21-25
 - ☐ 26-31
 - ☐ 32-36
 - ☐ 37-41
 - ☐ 42-47
 - ☐ 48-53
 - ☐ 54>

3. What is your ethnic background?
 - ☐ Hispanic
 - ☐ African American
 - ☐ Caucasian
 - ☐ Asian/Pacific Islander
 - ☐ Native American/Eskimo/Aleut
 - ☐ Other

4. What is your pay grade?

- ☐ O1-O3
- ☐ O4-O5
- ☐ O6>
- ☐ E-1-E4
- ☐ E-5-E6
- ☐ E7-E8
- ☐ E9
- ☐ WO1-CW2
- ☐ CW3-CW4
- ☐ CW5
- ☐ GS01-GS05
- ☐ GS06-GS09
- ☐ GS10-GS12
- ☐ GS13>
- ☐ Wage Grade
- ☐ Contract Civilian
- ☐ Other

5. What is your military status?

- ☐ Active Duty
- ☐ Activated Guard/Reserve
- ☐ Retired Military
- ☐ Some Prior Service Experience
- ☐ N/A

6. What is the highest education level attained?

- ☐ Some High School, but did not graduate or earn a GED
- ☐ High School Graduate or Equivalent
- ☐ Some College
- ☐ Associates Degree
- ☐ Bachelors Degree
- ☐ Masters Degree or Higher

7. How long have you worked for the federal government?

- ☐ <1 Year
- ☐ 1-3 Years
- ☐ 4-6 Years
- ☐ 7-10 Years
- ☐ 10-15 Years
- ☐ >15 Years

8. How long have you worked at Darnall Army Community Hospital?
- ☐ <1 Year
 - ☐ 1-3 Years
 - ☐ 4-6 Years
 - ☐ 7-10 Years
 - ☐ 10-15 Years
 - ☐ >15 Years
9. What description of employment do you perform?
- ☐ Senior Management
 - ☐ Middle Management
 - ☐ Supervisory
 - ☐ Professional
 - ☐ Paraprofessional
 - ☐ Administrator
 - ☐ Technical
 - ☐ Clerical
 - ☐ Labor
 - ☐ Other
10. What classification describes your primary function?
- ☐ Physician
 - ☐ Non-Physician Provider
 - ☐ Administrator
 - ☐ Medical Technician or Assistant
 - ☐ Medical Therapist or Technologist
 - ☐ Other
11. What degree of emphasis do you see placed on the hospital strategic plan?
- ☐ None
 - ☐ Low Degree
 - ☐ Moderate Degree
 - ☐ High Degree
 - ☐ Don't Know
12. Is the hospital structured correctly to perform its mission?
- ☐ Not Really
 - ☐ Minimally
 - ☐ Moderately
 - ☐ Highly
 - ☐ Don't Know

13. Are decisions made that supports the hospital?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
14. Is the hospital changing to support future demands?
- ☐ Not Really
 - ☐ Minimally
 - ☐ Moderately
 - ☐ Highly
 - ☐ Don't Know
15. Are hospital staff encouraged to be creative and inventive?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
16. Do hospital leaders use appropriate leadership and management techniques?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
17. What leadership style best characterizes your immediate supervisor?
- ☐ Authoritative/Dictatorial (Tells you exactly how the task will be accomplished).
 - ☐ Supportive (Open to suggestions).
 - ☐ Participative/Engaging (Encourages group thought).
 - ☐ Achievement/Goal Oriented (Focused on accomplishing the mission first).
 - ☐ Absence of Leadership

18. Is there a positive organizational climate, culture, and trust among staff?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
19. Are violations of unlawful actions identified and appropriate actions taken?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
20. Are potential liability issues addressed and actions taken to prevent malpractice claims?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
21. Does hospital leadership follow medical by-laws, policies, and regulations?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
22. Are current staffing levels assessed against needs and/or projected requirements?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know

23. Are opportunities for training, professional growth, and development afforded employees?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
24. Does the command climate promote a high level of morale and job satisfaction?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
25. Do hospital leaders follow proper labor relation procedures?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
26. Does hospital leadership ensure the proper upkeep and maintenance of the facility?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
27. What is the present condition of the hospital?
- ☐ Poor/Failing
 - ☐ Marginal/Needs Moderate Improvement
 - ☐ Adequate/Needs Minor Improvement
 - ☐ Good/Fully Adequate Environment of Care
 - ☐ Great/A Benchmark for Environment of Care

28. Does hospital leadership distinguish between right and wrong conduct?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

29. Do hospital leaders display both personal and professional ethical behavior?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

30. Are all incidents that involve harm or have the potential to harm a patient reported?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

31. Do hospital leaders promote a culture and climate that supports the organizational code of ethics?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

32. Are you coached and/or mentored by hospital leadership?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

33. Does hospital leadership openly communicate with you and solicit feedback?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
34. Does hospital leadership motivate others through effective communication, reinforcement, recognition, and/or reward?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
35. Do hospital leaders clearly define and articulate goals, tasks, purposes, and parameters?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
36. Do hospital leaders select decision-making techniques and problem solving approaches appropriate to the situation?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know
37. Does hospital leadership develop an organizational climate in which groups can openly deliberate and report findings without fear of reprisal?
- ☐ Not Really
 - ☐ Sometimes
 - ☐ Often
 - ☐ Mostly
 - ☐ Always
 - ☐ Don't Know

38. Do hospital leaders solicit and incorporate feedback, ideas, comments, and suggestions from others?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

39. Do hospital leaders monitor individual and/or group progress, providing interim guidance and intervention as necessary?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

40. Within a given year, how often are you counseled by management or supervisor?

- ☐ Never
- ☐ Once
- ☐ Twice
- ☐ \geq Three Times
- ☐ Don't Know

41. Do hospital leaders emphasize involvement, empowerment, and encourage continuous learning and reengineering efforts?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

42. Do hospital leaders involve key stakeholders in critical processes?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

43. Do hospital leaders make business decisions and solve problems based on results from quantitative and qualitative methods?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

44. Does hospital leadership employ best business and practice guidelines to enhance organization performance?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

45. Does the hospital have an effective patient safety and risk management program?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

46. Does hospital leadership employ tools and techniques to aid in risk analysis and reduction?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

47. Has hospital leadership implemented the National Patient Safety Goals and JCAHO Patient Safety Standards?

- ☐ Not Really
- ☐ Some
- ☐ Most
- ☐ All
- ☐ Don't Know

48. What degree of trust do you have in hospital leadership to make appropriate change(s) in the employee work environment?

- ☐ None
- ☐ Low Degree
- ☐ Moderate Degree
- ☐ High Degree
- ☐ Don't Know

You are finished. Please return the survey in a sealed distribution envelope to Major Steven Shipley, attention Army-Baylor Health Care Administration Resident, working in the DACH Command Group. Thank you. ☺

Appendix G
Management Self-Assessment Survey of Own Behavior

The purpose of this questionnaire design is to document your opinion about Management Behavior at Darnall Army Community Hospital (DACH). There are no right or wrong answers, simply answer all questions honestly. Please read each question carefully and check only one response per question. This questionnaire is completely anonymous. Your answers are confidential and all information gained in this study will only be presented as group data. Completion of this survey is voluntary and choosing not to complete the survey will not reflect poorly upon you in anyway. **Check only one response per question. Remember: Do not sign your name to this survey.**

1. What is your gender?
 - ☐ Male
 - ☐ Female

2. What is your age range?
 - ☐ 17-20
 - ☐ 21-25
 - ☐ 26-31
 - ☐ 32-36
 - ☐ 37-41
 - ☐ 42-47
 - ☐ 48-53
 - ☐ 54>

3. What is your ethnic background?
 - ☐ Hispanic
 - ☐ African American
 - ☐ Caucasian
 - ☐ Asian/Pacific Islander
 - ☐ Native American/Eskimo/Aleut
 - ☐ Other

4. What is your pay grade?

- ☐ O1-O3
- ☐ O4-O5
- ☐ O6>
- ☐ E-1-E4
- ☐ E-5-E6
- ☐ E7-E8
- ☐ E9
- ☐ WO1-CW2
- ☐ CW3-CW4
- ☐ CW5
- ☐ GS01-GS05
- ☐ GS06-GS09
- ☐ GS10-GS12
- ☐ GS13>
- ☐ Wage Grade
- ☐ Contract Civilian
- ☐ Other

5. What is your military status?

- ☐ Active Duty
- ☐ Activated Guard/Reserve
- ☐ Retired Military
- ☐ Some Prior Service Experience
- ☐ N/A

6. What is the highest education level attained?

- ☐ Some High School, but did not graduate or earn a GED
- ☐ High School Graduate or Equivalent
- ☐ Some College
- ☐ Associates Degree
- ☐ Bachelors Degree
- ☐ Masters Degree or Higher

7. How long have you worked for the federal government?

- ☐ <1 Year
- ☐ 1-3 Years
- ☐ 4-6 Years
- ☐ 7-10 Years
- ☐ 10-15 Years
- ☐ >15 Years

8. How long have you worked at Darnall Army Community Hospital?
 - ☐ <1 Year
 - ☐ 1-3 Years
 - ☐ 4-6 Years
 - ☐ 7-10 Years
 - ☐ 10-15 Years
 - ☐ >15 Years
9. What description of employment do you perform?
 - ☐ Senior Management
 - ☐ Middle Management
 - ☐ Supervisory
 - ☐ Professional
 - ☐ Paraprofessional
 - ☐ Administrator
 - ☐ Technical
 - ☐ Clerical
 - ☐ Labor
 - ☐ Other
10. What classification describes your primary function?
 - ☐ Physician
 - ☐ Non-Physician Provider
 - ☐ Administrator
 - ☐ Medical Technician or Assistant
 - ☐ Medical Therapist or Technologist
 - ☐ Other
11. What degree of emphasis do you place on the hospital strategic plan?
 - ☐ None
 - ☐ Minimal
 - ☐ Moderate
 - ☐ High
 - ☐ Don't Know
12. Is the hospital structured correctly to perform its mission?
 - ☐ Not Really
 - ☐ Minimally
 - ☐ Moderately
 - ☐ Highly
 - ☐ Don't Know

13. Do you make decisions that support the hospital?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

14. Is the hospital changing to support future demands?

- ☐ Not Really
- ☐ Minimally
- ☐ Moderately
- ☐ Highly
- ☐ Don't Know

15. Do you encourage hospital staff to be creative and inventive?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

16. Do you utilize appropriate leadership and management techniques?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

17. What leadership style best characterizes you?

- ☐ Authoritative/Dictatorial (Told exactly how the task will be accomplished).
- ☐ Supportive (Open to suggestions).
- ☐ Participative/Engaging (Encourages group thought).
- ☐ Achievement/Goal Oriented (Focused on accomplishing the mission first).
- ☐ Don't Have a Leadership Style

18. Do you create a positive organizational climate, culture, and trust among staff?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

19. Do you identify violations of unlawful actions and take appropriate actions?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

20. Do you address potential liability issues and take actions to prevent malpractice claims?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

21. Do you follow medical by-laws, policies, and regulations?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

22. Do you assess current staffing levels against needs and/or projected requirements?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

23. Do you provide employees with opportunities for training, professional growth, and development?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

24. Do you promote a command climate with a high level of morale and job satisfaction?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

25. Do you follow proper labor relation procedures?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

26. Do you ensure the proper upkeep and maintenance of the facility?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

27. What is the present condition of the hospital?

- ☐ Poor/Failing
- ☐ Marginal/Needs Moderate Improvement
- ☐ Adequate/Needs Minor Improvement
- ☐ Good/Fully Adequate Environment of Care
- ☐ Great/A Benchmark for Environment of Care

28. Can you distinguish between right and wrong conduct?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

29. Do you display both personal and professional ethical behavior?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

30. Do you ensure all incidents that involve harm or have the potential to harm a patient are reported?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

31. Do you promote a culture and climate that supports the organizational code of ethics?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

32. Do you coach and/or mentor hospital employees?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

33. Do you openly communicate with employees and solicit feedback?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

34. Do you motivate others through effective communication, reinforcement, recognition, and/or reward?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

35. Do you clearly define and articulate goals, tasks, purposes, and parameters?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

36. Do you select decision-making techniques and problem solving approaches appropriate to the situation?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

37. Do you develop an organizational climate in which groups can openly deliberate and report findings without fear of reprisal?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

38. Do you solicit and incorporate feedback, ideas, comments, and suggestions from others?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

39. Do you monitor individual and/or group progress, provide interim guidance and intervene as necessary?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

40. Within a given year, how often do you counsel employees?

- ☐ Never
- ☐ Once
- ☐ Twice
- ☐ \geq Three Times
- ☐ Don't Know

41. Do you emphasize involvement, empowerment, and encourage continuous learning and reengineering efforts?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

42. Do you involve key stakeholders in critical processes?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

43. Do you make business decisions and solve problems based on results from quantitative and qualitative methods?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

44. Do you employ best business and practice guidelines to enhance organization performance?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

45. Do you enforce the hospital's patient safety and risk management program?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

46. Do you employ tools and techniques to aid in risk analysis and reduction?

- ☐ Not Really
- ☐ Sometimes
- ☐ Often
- ☐ Mostly
- ☐ Always
- ☐ Don't Know

47. Have you implemented the National Patient Safety Goals and JCAHO Patient Safety Standards?

- ☐ Not Really
- ☐ Some
- ☐ Most
- ☐ All
- ☐ Don't Know

48. Do hospital employees trust you to make appropriate change(s) in their work environment?

- ☐ No
- ☐ Somewhat
- ☐ Considerably
- ☐ Very Much
- ☐ Don't Know

You are finished. Please return the survey in a sealed distribution envelope to Major Steven Shipley, attention Army-Baylor Health Care Administration Resident, working in the DACH Command Group. Thank you. ☺

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